

S. No. 2
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 14 1947

Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 7

1. PLACE OF DEATH:
 (a) County Linn
 (b) City or town Brookfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 3 weeks years, months or days) _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Linn 58
 (c) City or town Brookfield 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 2
 (e) Citizen of foreign country? no (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME LARRY DALE SLATER
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Mar day 2, year 1947 hour 6 minute 9 A.M.
 21. I hereby certify that I attended the deceased from Feb 9, 1947, to Mar 2, 1947
 that I last saw him alive on Feb 28, 1947
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Feb. 9, 1947
 (Month) (Day) (Year)

Immediate cause of death Spinal Bifida Duration 22 dy.

8. AGE: Years _____ Months _____ Days 22 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____

9. Birthplace Brookfield Mo.
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

10. Usual occupation _____

11. Industry or business _____

12. Name Lennie Slater

13. Birthplace Brookfield Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Ethel Jacobs

15. Birthplace West Columbia, Mo?
 (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) Burial (b) Date thereof Mar 2, 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maxima Cem.

18. (a) Signature of funeral director Personnel Services
 (b) Address Brookfield Mo.

19. (a) Mar 2 1947 (b) Walter B. Laurin
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place) _____
 (e) Means of injury Is

23. Signature W. W. Potter (M. D. or other) PO
 Address Brookfield Mo Date signed 3-2-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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(Licensed Embalmer's Statement on Reverse Side)

FEB 2-1948

DISTRICT HEALTH OFFICE
Cameron, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

E. A. Larson

Licensed Embalmer No. 4037

P. O. Address.....

Bucklin, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.