. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19811

Registration District No. 322 Primary Registration District No. 3071 Registrar's No.

1. PLACE OF DEATH:
(a) County: Saline
(b) City or town: Slater
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: none (Specify whether years, months or days)
In this community: all his life

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

3. (a) PRINT FULL NAME: John Henry Washington
3. (b) If veteran, name war: no
3. (c) Social Security No. none
4. Sex: male
5. Color or race: negro
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Lannie Washington
6. (c) Age of husband or wife if alive: 61 years
7. Birth date of deceased: June (Month) 24 (Day) 1875 (Year)
8. AGE: Years 71 Months 9 Days 23 If less than one day hr. min.
9. Birthplace: Saline County (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: retired R.R. shop laborer
11. Industry or business:
FATHER 12. Name: William Washington
13. Birthplace: (City, town, or county) Mo. (State or foreign country)
MOTHER 14. Maiden name: Stacy Ann Porter
15. Birthplace: (City, town, or county) Tenn. (State or foreign country)
16. (a) Informant: Ed Washington
(b) Address: Slater, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-20-'47 (Month) (Day) (Year)
(c) Place: burial or cremation: Slater, Mo.
18. (a) Signature of funeral director: Hill Brothers,
(b) Address: Slater--Mo.
19. (a) Apr. 29, 1947 (Date received local registrar) (b) Mrs. Earl C. Metz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17th year 1947 hour 9 minute a.m.
21. I hereby certify that I attended the deceased from March 28, 1947, to April 17, 1947, that I last saw him alive on April 17, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia	4 hr.
Due to Ch. Myocarditis	2 hr.
Due to Hodgkin's Disease	5 yr.
Other conditions (Include pregnancy within 3 months of death) Hypertrophic Ch.	?

Major findings: Of operations: None
Of autopsy: None

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): No.
(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? (Specify type of place)
While at work (c) Means of injury:
23. Signature: N. E. Lockwood (M. D. or other)
Address: Slater Mo. Date signed: 7-18-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 5-15-47

JUL 15 1947

AUG 29 1947

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 A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Slater 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.