

No. 2  
12-45  
-17-39  
X47070

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33027**  
Registrar's No. **9005**

FILED OCT 4 1947

Registration District No. **318** Primary Registration District No. **1003**

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis **96**  
(c) City or town Overland **13**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2705 Tennyson Ave. **1**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No) **1**  
If yes, name country.....

3. (a) PRINT FULL NAME Slawson, John B.  
3. (b) If veteran, name war -  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Martha  
6. (c) Age of husband or wife if alive 13 years  
7. Birth date of deceased January 13 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
84 8 13 hr. min.

9. Birthplace Russellville Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Blacksmith

11. Industry or business.....

12. Name John Slawson  
13. Birthplace Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bryant  
15. Birthplace Knox County Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Dodd Slawson  
(b) Address 5853 Highland Ave.

17. (a) Burial (b) Date thereof 9/29/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Resurrection

18. (a) Signature of funeral director Stroot-Carroll  
(b) Address 4600 Natural Bridge Ave.

19. (a) SEP 27 1947 (b) J. J. Bredbeck  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 26  
year 47 hour 1 minute 30 P.M.  
21. I hereby certify that I attended the deceased from 9-16 to 9-26, 1947  
that I last saw him alive on 9-26, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident - Hemorrhage. Duration 4 hr  
Due to Arteriosclerotic cardio vascular disease - Hypertension 10 yr  
Due to.....

Other conditions Bladder Hemorrhage. 2 wks  
(Include symptoms which occurred prior to death)  
CAUSE UNDETERMINED

Major findings: BENIGN Prostatic Hypertrophy - Atrophy of Prostate  
deafness  
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).....  
(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.....  
Dr. Stephens (M. D. or other) Mo.  
Missouri Nat. Hosp Date signed 9/26/47  
Dr. Jones

**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..... *Benjamin Hoffman*

Licensed Embalmer No. *14366*

P. O. Address..... *Harve...*

**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.**