No. 300
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5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 15 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19762

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 200

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

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Independence (If outside city or town limits, write "RURAL")
(d) Street No. 315 North Spring St. (If rural, give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME FRANK ALLEN SLOAN
3. (b) If veteran, name war IVO
3. (c) Social Security No. IVO
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Venus Sloan
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased 10-23-1886 (Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 11 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation Postal Service
11. Industry or business ✓
FATHER
12. Name James Sloan
13. Birthplace (City, town, or county) Ky. (State or foreign country)
MOTHER
14. Maiden name Mary Settle
15. Birthplace (City, town, or county) Va. (State or foreign country)
16. (a) Informant Mrs. Frank Sloan
(b) Address 315 N. Spring St. Ind
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/48 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cem.
18. (a) Signature of funeral director Stine & McClure
(b) Address Kansas City, Mo.
19. (a) 7-6-48 (Date received local registrar) (b) James S. Craig 351 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4 year 1948 hour 1 minute A M.
21. I hereby certify that I attended the deceased from July 1, 1948 to July 4, 1948 that I last saw him alive on July 3, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary occlusion	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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)
(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? (e) Means of injury
23. Signature J. W. Greene (M. D. ~~or other~~)
Address Independence Date signed 7/4/48

(Licensed Embalmer's Statement on Reverse Side)

319 North Spring
" Ind.

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 Emery M. Plank

Licensed Embalmer No. 1848

P. O. Address K. C. 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.

S. No. 2B
M—3-45
I X43880

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. July

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 200

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Frank A Sloan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive (Years)

7. Birth date of deceased Aug 23 (Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)
(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? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-19762