

FILED APR 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9555

BIRTH NO. _____ REG. DIST. NO. 193 PRIMARY REG. DIST. NO. 5709 Registrar's No. 45

0600

0600

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

1. PLACE OF DEATH a. COUNTY McDonald		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY McDonald	
b. CITY (If outside corporate limits, write RURAL and give town or township) Rural-Erie twp.	c. LENGTH OF STAY (in this place) 45 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) Rural-Erie twp.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Goodman, Rt. 1		d. STREET ADDRESS (If rural, give location) Goodman, Rt. 1	

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) HENRY c. (Last) SLAGLE			4. DATE OF DEATH (Month) (Day) (Year) April 3, 1950		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 4, 1872	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Harrison, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Slagle	13b. MOTHER'S MAIDEN NAME Nancy Jane Rainor	14. NAME OF HUSBAND OR WIFE Martha Weatherly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 490-14-4004	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Martha W. Slagle, Goodman, Rt. 1 Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 331X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Failure of Cardiac & Respiratory Centers		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) cerebral and Pontine Hemorrhage DUE TO (c) Senile hypertension		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 31, 1950, to April 3, 1950, that I last saw the deceased alive on April 3rd, 1950, and that death occurred at 8:50 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harold G. Ward, D.O.	23b. ADDRESS Goodman, Mo.	23c. DATE SIGNED 4/5/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-7-1950	24c. NAME OF CEMETERY OR CREMATORY Howard Cemetery
		24d. LOCATION (City, town, or county) (State) Goodman, Missouri

DATE REC'D BY LOCAL REG. 4/12/50	REGISTRAR'S SIGNATURE Mrs. Fred Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John B. Papineau Goodman, Mo.
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *John B. Papineau*

Licensed Embalmer No. *4446*

P. O. Address *Goodman*

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.