

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27839**

No. 300
10.48

FILED SEP 8-1953

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 927

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Joseph</u>	
c. LENGTH OF STAY (in this place) <u>5 yr.</u>		d. STREET ADDRESS (If rural, give location) <u>1211 So. 22 nd. St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1211 So. 22 nd. St.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Norma</u> b. (Middle) <u>Ann</u> c. (Last) <u>Slaybaugh</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 23 1953</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>11/29/1873</u>		9. AGE (In years last birthday) <u>79</u>		10. F UNDER 1 YEAR Days _____ 11. F UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Stewartsville, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>David Fairfield</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hobbs</u>	
14. NAME OF HUSBAND OR WIFE <u>James R. Slaybaugh</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. John DeMond</u>		ADDRESS <u>St Joseph, Mo.</u>			

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>chronic myocarditis</u>				not same not same	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
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) <u>H221</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 Aug 20 1953, to Aug 23 1953 that I last saw the deceased alive on Aug 23, 1953, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Collis P. Rounley M.D.</u>		23b. ADDRESS <u>St Joseph Mo. 7th & Pacific Bldg</u>		23c. DATE SIGNED <u>Aug 24</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/26/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Independence</u>	
24d. LOCATION (City, town, or county) (State) <u>Ill. N. - Hemple Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.E. Summerfield</u>		ADDRESS <u>Stewartsville, Mo.</u>	

DATE REC'D BY LOCAL REG. Aug 29, 1953

REGISTRAR'S SIGNATURE Bother M. Allison 485

25. FUNERAL DIRECTOR'S SIGNATURE W.E. Summerfield ADDRESS Stewartsville, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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 W.E. Summerfield

Licensed Embalmer No. 3007

P. O. Address Stewartville, 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.