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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 28 1956

38241
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4933

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 1320 Troost — Length of stay in 19 39 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 3454 Montgall — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First MILDRED Middle GERALDINE Last SLAUGHTER
4. DATE OF DEATH Month Day Year November 10, 1956

5. SEX Female 3
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X 3
8. DATE OF BIRTH 2/11/1915
9. AGE (In years last birthday) 41 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Chillocothe, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Burt Slaughter
14. MOTHER'S MAIDEN NAME o.K. Martha Alice Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT o.K. Martha Alice Brown Address 3454 Montgall

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock
INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Internal Hemorrhage
Penetrating Gunshot wound of Chest
DUE TO (c) Penetrating Gunshot Wound of Abdomen.
E 981 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES X NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE X
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dont Know
20c. TIME OF INJURY Hour ~~a.m.~~ p.m. Month, Day, Year 10:50 Nov. 10, 1956
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 1320 Troost Ave
20f. CITY, TOWN, OR LOCATION Kansas City, COUNTY Jackson, STATE Mo.

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or Title) L. M. Tillman M.D. Deputy Coroner 3
22b. ADDRESS 1618 Lydia Ave
22c. DATE SIGNED 11/14/56

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 11/19/56
23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

24. FUNERAL DIRECTOR WATKINS BROS. FN. HM. ADDRESS 18th & Benton
25. DATE RECD. BY LOCAL REG. 11-14-56
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

L. M. Tillman

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. Bruce R. Watkins

Licensed Embalmer No. 4-

P. O. Address 18th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.