

FILED NOV 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

35547

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1257

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth Hosp.</b>		Length of stay in 1b <b>Lifetime</b>	d. STREET ADDRESS (If outside, give location) <b>2115 S. 9th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Otto</b> Middle <b>Murl</b> Last <b>Slater</b>			4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1957.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1916</b>	9. AGE (In years last birthday) <b>41</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rock Island RR</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Murl Slater</b>		13b. MOTHER'S MAIDEN NAME <b>Clara Hinze</b>		14. NAME OF HUSBAND OR WIFE <b>Iona Slater</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-09-1380</b>		17. INFORMANT Address <b>Mrs. Iona Slater St. Joseph, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia with acidosis, secondary anemia, and coma.</b> INTERVAL BETWEEN ONSET AND DEATH <b>months</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Inter-capillary glomerulosclerosis.</b> <b>yrs.</b> DUE TO (c) <b>Diabetes melitus with secondary vascular deterioration.</b> <b>23 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>260X</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>4/23/56</b> to <b>11/14/57</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>11/13/57</b> Death occurred at <b>9:10 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Karyl G. Toller, Jr. M.D.</b>			22b. ADDRESS <b>Physicians &amp; Surgeons Bldg. St. Joseph, Mo.</b>		22c. DATE SIGNED <b>11/19/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE <b>Nov. 16, 1957.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 21, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 .....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. 4679 .....

P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.