

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023760
STATE FILE NUMBER

FILED JUN 24 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5333

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 St. Louis City Hospital # 1		Length of stay in lb 1257	d. STREET ADDRESS (If outside, give location) # 11 North 6th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Forrest Middle Slaughter Last			4. DATE OF DEATH Month May Day 19 Year 1958		
5. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1905		9. AGE (In years last birthday) 52 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) Printers Helper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Samuel Slaughter		13b. MOTHER'S MAIDEN NAME Luvornia McQueen		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Frank Kubik, 601 East 9th St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism of Arterio Sclerosis					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio Sclerosis					
DUE TO (c) 581.0					
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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NOT WHILE AT <input type="checkbox"/> WORK		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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ 130A on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Patrick Taylor Corvus (Degree or title)			22b. ADDRESS 1300 Clark		22c. DATE SIGNED 5-20-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-20-58	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) Michigan City, Indiana.
24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington, Blvd			25. DATE RECD. BY LOCAL REG. MAY 20 58		26. REGISTRAR'S SIGNATURE Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Stanley H. Dixon*
Licensed Embalmer No. *4193*
P. O. Address *St. L.*

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.