

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035030
- STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2453

300
1-57

| | | | | | |
|---|----------------------------------|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ST. LOUIS | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Ferguson 4119 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp. | | Length of stay in lb 4 Days | d. STREET ADDRESS (If outside, give location) 233 Tiffin Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First William Middle Johnston Last Slater | | | 4. DATE OF DEATH Month 9 Day 22 Year 58 | | |
| 5. SEX Male | 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 1-8-94 | | 9. AGE (In years birthday) 64 |
| 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) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Brooks Paper Co. | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13a. FATHER'S NAME Harry M. Slater | | 13b. MOTHER'S MAIDEN NAME Eugenia Long | | 14. NAME OF HUSBAND OR WIFE None Josephine Slater | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) Yes W. W. I | | 16. SOCIAL SECURITY NO. unk. | | 17. INFORMANT Eugenia Slater Address 233 Tiffin Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchial pneumonia | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 days 10 yrs |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) acute stenosis of aorta | | | | | |
| DUE TO (c) decompensation | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4211 | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 4211 | | |
| 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 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 July 1958 to Sept 22 1958 and last saw ^{her} him alive on Sept 22 1958 Death occurred at 7:00PM on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Fred Kramer M.D. (Degree or title) | | | 22b. ADDRESS 4161 Lindell Blvd. | | 22c. DATE SIGNED 9-23-58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 9-24-58 | 23c. NAME OF CEMETERY OR CREMATORY Fee Fee Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. |
| 24. FUNERAL DIRECTOR White-Mullen Mort. ADDRESS 118 N. Florissant | | | 25. DATE RECD. BY LOCAL REG. 9-23-58 | 26. REGISTRAR'S SIGNATURE Herbert G. Donke M.D. | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. F. Kramer
1: to 6:00PM

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 *Eleanore Poynce*

Licensed Embalmer No. *3403*
P. O. Address *Jennings*

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.