URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-042523

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210578

ENDED

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, Missouri. | Length of stay in 1b

c. CITY OR TOWN St. Louis | Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3417a Meramec Street., | Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 3417a Meramec Street., | Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Mabel Middle Virginia Last Sloss

4. DATE OF DEATH Month Day Year November 13, 1959

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 4/16/1889

9. AGE (last birthday) 70 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (City and state or country) Parsons, Kansas.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Daniel T. House

13b. MOTHER'S MAIDEN NAME Virginia Dare Williams

14. NAME OF HUSBAND OR WIFE Robert Sloss, dec'd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) Nil

16. SOCIAL SECURITY NO. 490-20-7086

17. INFORMANT Ladd Sloss, 1926 South Franklin Colorado Springs, Colorado. Address

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 Hemorrhage

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Hypertension (arteriosclerotic)

DUE TO (c) 331+

INTERVAL BETWEEN ONSET AND DEATH 4 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT 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 8-10-59, to 11-13-59 and last saw her alive on 11-12-59

Death occurred at 9:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Andrew G. Klein, M.D.

22b. ADDRESS 4632 So. Grand Blvd

22c. DATE SIGNED 11-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 11/16/59

23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri.

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington

25. DATE RECD. BY LOCAL REG. NOV 16 1959

26. REGISTRAR'S SIGNATURE Carl Smith, M.D. MJL

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Harvey Kahle

Signature of Student Embalmer

Licensed Embalmer No. 4596

P. O. Address St Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.