JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1960

-60-036572

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9081

NDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Indiana b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis

Length of stay in 1b: 31 days

c. CITY OR TOWN Hammond,

Inside Limits: Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospitals, Inc.

Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 7745 Beach Ave.,

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Roy; Middle Lee; Last Sloan

4. DATE OF DEATH: Month Sept. Day 12, Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 11/19/1898

9. AGE (last birthday): 61 yrs.

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): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (City and state or country): Fairfield, Ill.

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

13a. FATHER'S NAME: Unknown Sloan

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Tressa Michaels

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.: 703-01-2014

17. INFORMANT: Mrs Kathryn Bursott Address 7745 Beach Ave Hammond. Indiana.

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): Pulmonary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 month.

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

DUE TO (b): Asthma, bronchial, chronic — 2 years

DUE TO (c): 241 x

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

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 Aug. 13, 1960 to Sept. 12, 1960 and last saw her/him alive on Sept. 12, 1960

Death occurred at 1:30 P.M., m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. C. Treiman, M.D. (Degree or title)

22b. ADDRESS: 1755 South Grand Blvd.,

22c. DATE SIGNED: 9/13/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 9/15/1960

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY: Valhalla Crematory

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

24. FUNERAL DIRECTOR: E.J.Schnur Funeral Home ADDRESS 3125 Lafayette St.Louis, Mo.

25. DATE REC'D. BY LOCAL REG.: SEP 14 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

BY AFFIDAVIT OF DOCUMENT

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 Thomas R. Tenevi

Signature of Student Embalmer

Licensed Embalmer No. 3793

P. O. Address 3125 Lag

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