

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037757

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1212 STATE FILE NUMBER

FILED OCT 29 1962

1. PLACE OF DEATH
 a. COUNTY Buchanan
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in 1b 1 Year
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Methodist Hospital Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 1316 Atchison St. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Phyllis Middle June Last Slaughter 4. DATE OF DEATH Month Oct. Day 23 Year 1962

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 9/6/1937 9. AGE (last birthday) 25 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (City and state or country) Troy Kansas 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Harold Sharp 13b. MOTHER'S MAIDEN NAME Iva McConnell 14. NAME OF HUSBAND OR WIFE Carl S. Slaughter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Carl S. Slaughter Address 1316 Atchison. ST. St. Joseph Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Ruptured Cerebral Aneurysm
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)
 DUE TO (b) _____
 DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None 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 4/46/58 to 10/23/62 and last saw her him alive on 10/23/62 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE S. C. Benson M.D. (Degree or title) 22b. ADDRESS 324 N. 6th 22c. DATE SIGNED 10/24/62

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 10/23/62 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive 23d. LOCATION (City, town, or county) Troy Kansas

24. FUNERAL DIRECTOR Vernon B. Jillette ADDRESS Troy Kansas 25. DATE RECD. BY LOCAL REG. Oct. 25, 1962 26. REGISTRAR'S SIGNATURE Mrs. Clark Standell

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

S.C. Benson, M.D. MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

NOV 7 1962

Permit issued 10/24/62

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 Charles E Bennett

Licensed Embalmer No. 4637

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.