

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-023027

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 329 Primary Registration District No. 2253 Registrar's No. 1

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 1110

2 1110

3

4 1

5 0

6

7 0

8 2

9422.1

10

11

12 90-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 28 1963	
1. PLACE OF DEATH	
a. COUNTY <u>Wayne</u>	b. CITY (if outside corporate limits, give TOWNSHIP only) <u>Blackriver Township</u>
c. FULL NAME OF (IF NOT in hospital, give location) <u>Home</u>	Length of stay in lb <u>Life</u>
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. STATE <u>Mo</u>	b. COUNTY <u>Wayne</u>
c. CITY OR TOWN <u>Williamsville</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. STREET ADDRESS <u>R.R.</u>	(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	
First <u>Edna</u>	Middle <u>(X)</u>
Last <u>Sloan</u>	4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13-92</u>
9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>
11. BIRTHPLACE (City and state or country) <u>Wayne Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Samuel D. Sloan</u>	13b. MOTHER'S MAIDEN NAME <u>Alma Haynes</u>
14. NAME OF HUSBAND OR WIFE <u>None</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>
16. SOCIAL SECURITY NO. <u>[Redacted]</u>	17. INFORMANT <u>Mrs. Blanch Smith Williamsville Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line)	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensat</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <u>Chronic myocarditis</u>	<u>5 yrs</u>
DUE TO (c) <u>Generalized arteriosclerosis</u>	<u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <u>mental retardation</u>	
PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. 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 <u>[Redacted]</u> a.m. <u>[Redacted]</u> p.m. <u>[Redacted]</u> Month, Day, Year <u>[Redacted]</u>	
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 <u>8/15/61</u> to <u>5/17/63</u> and last saw her alive on <u>5/1/63</u> Death occurred at <u>about 3:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Cyril A. Post M.D.</u>	22b. ADDRESS <u>Poplar Bluff Mo.</u>
22c. DATE SIGNED <u>5/22/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-19-63</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Sloan Cemetery</u>	23d. LOCATION (City, town, or county) <u>Wayne Co. Mo.</u>
24. FUNERAL DIRECTOR <u>William Cook Piedmont Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 24, 1963</u>
26. REGISTRAR'S SIGNATURE <u>Shirley Loulson</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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 Coder Funeral Home, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Coder

Licensed Embalmer No. 3723

P. O. Address Piedmont, 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.