WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

33005

PLACE OF DEATH

County Cape Girardeau

Township Welch

or

Village

or

City (NO. , St.: Ward)

Registration District No. 122

Primary Registration District No. 5175

File No.

Registered No. 18

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME George Washington Slinkard

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Mar. (Month) 8 (Day), 1858 (Year)

AGE: 57 yrs. 8 mos. 22 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Burfordsville, Mo. Cape Girardeau Co.

PARENTS

NAME OF FATHER: [illegible] Slinkard

BIRTHPLACE OF FATHER (City or town, State or foreign country): Does not know

MAIDEN NAME OF MOTHER: Does not know

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Does not know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Guy Slinkard

(ADDRESS) Allenville Mo

Filed Nov. 29, 1915, E. E. Higdon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov. (Month) 29 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 27, 1915, to Nov. 29, 1915, that I last saw him alive on Nov 28, 1916, and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

108 [illegible]

1946

(Duration) ___ yrs. ___ mos. 7 ds.

Contributory (SECONDARY): Exposure to rain

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. M. Finney M. D.

Nov. 29, 1915 (Address) Whitewater Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Burfordsville, Mo.

DATE OF BURIAL: Nov 30, 1915

UNDERTAKER: [illegible] Hinton

ADDRESS: Allenville Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1 _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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