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

Do not use this space.

29452

File No. .....

Registered No. 143

1. PLACE OF DEATH

County: Audrain — Registration District No. 26

Township: ~~Salt River~~ — Primary Registration District No. 3002

City: Mexico (No. ....., ... St. ..... Ward)

2. FULL NAME: Maxene Slavens

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
Female	White	Single

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct.-4-1927

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Mexico Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER John Dean Slavens

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Gertrude Stuart

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

14. INFORMANT J.D.Slavens
(Address) Farber Mo.

15. Oct 26th 27 Ira S. Milligan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct.-4- 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct.4- 1927, to Oct.-5- 1927 that I last saw her alive on Oct.5 1927, and that death occurred, on the date stated above, at 11.20 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth
(Twin)
159
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Eclampsia of Mother
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Place of death

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W.K.McCall, M. D

10-6-, 1927 (Address) Laddonia Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Laddonia Mo.

DATE OF BURIAL: Oct-6-1927

20. UNDERTAKER: H.G.Grainger

ADDRESS: Laddonia Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.