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

Do not use this space.

35011

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9985

City ST. LOUIS, MO (No. Barnes Hospital St. ..... Ward)

2. FULL NAME GREENFIELD SLUDER

(a) Residence. No. 4935 Maryland Pl. St., 12 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ella Cochran Sluder

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 30 1865

7. AGE: Years 63 | Months 1 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Physician 107A 97
(b) General nature of industry, business, or establishment in which employed (or employer): — 98B
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): St. Louis
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: Aaron Sluder
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Nashville
(STATE OR COUNTRY): Tennessee
12. MAIDEN NAME OF MOTHER: Martha Greenfield
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Nashville
(STATE OR COUNTRY): Tennessee

14. INFORMANT: John C. Sluder
(Address): 4935 Maryland ave

15. FILED OCT 11 1928, 19.. Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 10 — 9 — 1928

17. I HEREBY CERTIFY, That I attended deceased from 10-7, 1928, to 10-9, 1928 that I last saw him alive on 10-9, 1928, and that death occurred, on the date stated above, at 8:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia (Terminal)

100W (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Arteriosclerosis general
Gangrene of leg - Rt non Dialectic arteriosclerotic (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? amputation of Leg

2 DID AN OPERATION PRECEDE DEATH? yes DATE OF 10-7-28

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Norwood, M.D.

, 19 (Address) 600 S. Kingshighway

*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: Bellefontaine
DATE OF BURIAL: Oct 11th 1928

20. UNDERTAKER: Wagoner
ADDRESS: 3621 Olive

V. S. No. 2. MARGIN RESERVED FOR BINDING

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.