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

Do not use this space.

13763

1. PLACE OF DEATH

County Audrain — Registration District No. 27 — File No. 3

Township Linn — Primary Registration District No. 5730 — Registered No. 3

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Thomas Jefferson Slavens

(a) Residence. No. ..... St., ... 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: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 21-1929

7. AGE: Years 71 | Months 6 | Days ~~13~~ 12 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pike Co. Mo.

PARENTS

10. NAME OF FATHER W. F. Slavens
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Frances Ann McCoy
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT Miss Anna Slavens
(Address) Rush Hill Mo.

15. April 30, 1929 W E Smith REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 3- 1929

17. I HEREBY CERTIFY, That I attended deceased from March-29-, 1929, to April 3-, 1929 that I last saw ~~him~~ alive on April 2-, 1929, and that death occurred, on the date stated above, at 8 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy

820

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis

(duration) 1 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? Physical signs

(Signed) W K McCall, M. D

4-4-, 1929 (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: West Cuivre Church — DATE OF BURIAL: 4/5 1929

20. UNDERTAKER: H G Granger — ADDRESS: Laddonia, Mo.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County Audrain — Registration District No. 27 — File No. 3
Township Linn — Primary Registration District No. 5735 — Registered No.
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Thomas Jefferson 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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 21-1857

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
71	6	12	

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) (STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 6-10-1929 ~~W K McCall~~ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 3 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D.
, 19 (Address)

*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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

S-13763