

SEP 24 1930

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

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1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
Township _____ Primary Registration District No. 2001 Registered No. 625
City Springfield (No. Springfield District Hospital St. _____ Ward)

2. FULL NAME

(a) Residence. No. Forsyth St., no. 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 18 - 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 7 29

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).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

10. NAME OF FATHER Nathaniel Slifer

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

12. MAIDEN NAME OF MOTHER Mary Slifer

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

14. INFORMANT Mrs. Emma Slifer
(Address) Forsyth Mo

15. FILED 8/15, 1930 Gov Sharp REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 17 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug 17, 1930, that I last saw her alive on Aug 16, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Aneurysm of aorta
96
9311 (duration) yrs. 2 mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis
(duration) yrs. 2 mos. ds.

18. WHERE WAS DISEASE CONTRACTED At home
LEAD AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS XRay
(Signed) Ray DeCallaway, M. D.
8-17, 1930 (Address) Springfield Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forsyth Mo. DATE OF BURIAL Aug 18 1930

20. UNDERTAKER R. D. Welchel ADDRESS Branson Mo

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.

