

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

Do not use this space.

✓ 12724

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City Albion Mo (No. City Hospital #1) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 4044  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

William H. Slater  
 (a) Residence. No. 6035 E. Main Ave St. 3 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 (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4 - 1840

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
90 7 27

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

9. BIRTHPLACE (CITY OR TOWN) England  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER Mr. Bester

11. BIRTHPLACE OF FATHER (CITY OR TOWN) England  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT C. W. Gester  
 (Address) 6035 E. Main Ave

15. FILED May 2 1931 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1931

17. No Physician in Attendance  
 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 6:25 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Black Injury (Critical Hemorrhage of Brain - Fractured skull by auto in St. Louis Mo. Deceased was a pedestrian.  
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Accident  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) J. W. Kemmer, M.D.  
4/1, 1931 (Address) Dr. Cerovec

\*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 Oak Hill DATE OF BURIAL 5/2 1931

20. UNDERTAKER Wm. Amburster and Co 4234 Manchester Ave ADDRESS \_\_\_\_\_

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.

