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.

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

FEB 12 1938

791

572
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 428
(c) City St Louis Mo (d) Street No. at Homer G. Phillips Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Max Slaughter 423
(a) Residence, No. 2020a Carr St. 21
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE Col
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Carrie Slaughter
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 9, 1883
7. AGE YEARS 54 MONTHS 9 DAYS 28 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W. P. A
9. Industry or business in which work was done, as saw mill, bank, etc. Laborer
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hopkinsville Ky.

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Carrie Slaughter 2020a Carr St.
18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE Jan 13 1938
19. FUNERAL DIRECTOR (ADDRESS) A. F. (Buddie) Walton 2707 Stoddard St.
20. FILED JAN 13 1938 19 J F Biedeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

NO PHYSICIAN IN ATTENDANCE

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/6/38 , 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 10:46 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Sclerosis (Thrombus)	
Chronic Parenchymatous Nephritis	
Diffuse Arterio Sclerosis.	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Alfred J Perry M. D.
(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, Lonnie Boykin, Licensed Embalmer No. 2946

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Lonnie Boykin

Licensed Embalmer No. 2946

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)