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.

REC'D DEC 12 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 791

37475
Do not use this space.

Registration District No. 1008
Primary Registration District No.
Registered No. 9802

1. PLACE OF DEATH
(a) County
(b) Township
(c) City St. Louis (d) Street No. City Hospital No.1 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. 6 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D. 11691

2. PRINT FULL NAME 423 Wayne Slaughter
(a) Residence, No. 715 Hickory St. 22
(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 white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Billie Slaughter
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 8, 1903
7. AGE YEARS 35 MONTHS 3 DAYS 3 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unemployed
9. Industry or business in which work was done, as saw mill, bank, etc. nil
10. Date deceased last worked at this occupation (month and year) 1930
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER
13. NAME William Slaughter
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
15. MAIDEN NAME Etta Qualls
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Hosp. Info M. Kent
(ADDRESS) ALICE Day - 715 HICKORY
18. BURIAL, CREMATION, OR REMOVAL
PLACE REPUBLIC, MO DATE NOV 14, 1938
19. FUNERAL DIRECTOR (NAME) Albert H. Hoppe Inc
(ADDRESS) 4700 Washington
20. FILED NOV 12 1938 J. F. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/10/38, 19

22. I HEREBY CERTIFY, That I attended deceased from 11/9/38, 19 to 11/10/38, 19
I last saw him alive on 11/10/38, 19. Death is said to have occurred on the date stated above, at 8 .45 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary tuberculosis	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No.

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?
If so, specify
(Signed) Rice Maxwell, M. D.
(Address) City Hospital No.1

Licensed Embalmer's Statement on Reverse Side)

Em blank signed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.