

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

37307

Registration District No.

798

Primary Registration District No.

4479

Registrar's No.

51

1. PLACE OF DEATH:

(a) County: Saline  
(b) City or town: Slater  
(c) Name of hospital or institution: none

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 50 yrs  
(Specify whether years, months or days)

3. (c) PRINT FULL NAME: Harold Glenn Alexander

8. (b) If veteran, name war: no 3. (c) Social Security No.:

4. Sex: male 5. Color or race: white 6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Ella Alexander 6. (c) Age of husband or wife if alive: 51 years

7. Birth date of deceased: December 15th 1887  
(Month) (Day) (Year)

8. AGE: Years: 51 Months: 10 Days: 13 If less than one day: 2 hr. min.

9. Birthplace: Corry, Penn.  
(City, town, or county) (State or foreign country)

10. Usual occupation: R.R. Conductor

11. Industry or business:

12. Name: Jno. G. Alexander

13. Birthplace: Pennsylvania  
(City, town, or county) (State or foreign country)

14. Maiden name: Edith Fuller

15. Birthplace: Pa.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Ella Alexander

(b) Address: Slater, Mo.

17. (a) burial (b) Date thereof: 10/31/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Slater, Mo.

18. (a) Signature of funeral director: Hill Brothers

(b) Address: Slater, Mo.

19. (a) Oct 30 (b) W. M. Little  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: No. (b) County: Saline

(c) City or town: Slater  
(If outside city or town limits, write "RURAL")

(d) Street No.: (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct. day: 28th  
year: 1939 hour: 11 a m minute: M.

21. I hereby certify that I attended the deceased from Feb. 23, 1939 to Oct 27, 1939  
that I last saw him alive on Oct 27, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death: Angina Pectoris Duration: 6 weeks

Due to: Ch. myocarditis ?

Due to:

Other conditions: 94  
(Include pregnancy within 3 months of death)

Major findings: Of operations:

Of autopsy: None

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature: C. A. McTurney (M. D. or other)

Address: Slater, Mo. Date signed: 10/30/39

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 11/6/39

---

---

**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 comply with the above constitutes grounds for revocation of license.)**

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