

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

**37351**  
 Do not use this space.

RECD NOV 14 1939

**1. PLACE OF DEATH**

(a) County Scott Registration District No. 820  
 (b) Township Sylvania Primary Registration District No. 607  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ 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** William Jefferson Slinkard

(a) Residence, No. Chaffee, Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**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 Mary Elizabeth Slinkard

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 29, 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hra. or .....min.  
79 10 11

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

12. BIRTHPLACE (CITY OR TOWN) Bollinger County  
 (STATE OR COUNTRY) Mo

FATHER 13. NAME James Slinkard

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME Mary Allen

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT Mary Elizabeth Slinkard  
 (ADDRESS) Chaffee Mo

18. BURIAL, CREMATION, OR REMOVAL Bollinger Co. Mo DATE 10/13/39  
Bollinger Cem.

19. FUNERAL DIRECTOR (NAME) Bispling & Hubbard  
 (ADDRESS) Chaffee, Mo

20. FILED 11-20, 1939 W. J. Slinkard  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-10, 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-7, 1939, to 10-9, 1939

I last saw him alive on 10-9, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 2:30 P.m.

The principal cause of death and related causes of importance were as follows:

Valvular Heart disease

Date of onset

Other contributory causes of importance:

Senility

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? No.

If so, specify \_\_\_\_\_

(Signed) W. J. Slinkard M.D.

(Address) Chaffee, 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.

RECEIVED FILED STATE OFFICE  
INDEX CARD RETURNED TO DISTRICT  
DATE 11/14/44

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**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.**