

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

6587

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAR 2 1940

5427

6

1. PLACE OF DEATH:

- (a) County Gentry "Rural" Athens
(b) City or town Athens
(c) Name of hospital or institution: 2

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

- (d) Length of stay: In hospital or institution

(Specify whether

In this community
years, months or days)

3. (a) PRINT FULL NAME Albert Grant Slater 436

3. (b) If veteran,

name war

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

Ray Seg6 Slater

6. (c) Age of husband or wife if

alive years

7. Birth date of deceased May 23

(Month)

23 1882

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

57

8

10

hr.

min.

9. Birthplace Denver

(City, town, or county)

Mo.

(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

12. Name Unknown 9

13. Birthplace Unknown

(City, town, or county)

(State or foreign country)

14. Maiden name Unknown 9

15. Birthplace Unknown

(City, town, or county)

(State or foreign country)

16. (a) Informant Mrs. Grant Slater

- (b) Address Albany, Mo.

17. (a) Burial

(Burial, cremation, or removal)

- (b) Date thereof Feb. 3, 1940

(Month) (Day) (Year)

- (c) Place: burial or cremation New Friendship

18. (a) Signature of funeral director Clifford Brooks

- (b) Address Albany, Mo.

19. (a) Feb 3 1940 (b) H. H. Martin

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Gentry

- (c) City or town Rural

(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 Feb. day 3
year 1940 hour 12:30 A.M./minute M.

21. I hereby certify that I attended the deceased from

2-1- 1939 to 2-3- 1940;

that I last saw him alive on 2-3- 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death

Sanguine left leg.

Duration

1 week

Due to Endarteritis Obliterans

1 year +

Due to

Other conditions Myocarditis

(Include pregnancy within 3 months of death)

4 yrs

Major findings:

Of operations amputations both limbs

during 1939

Of autopsy

PHYSICIAN

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 Frank H. Rose

(M. D. or other) M.D.

Address Albany

Date signed 2-3-40

RECEIVED
District Health Officer No. 11;
District File Number 340-232
Date Filed MAR 5 1940

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

Signed _____

Licensed Embalmer No. 3329

P. O. Address Albany, Mo.

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.