

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

FILED APR 22 1940

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

10792
Do not use this space.

1. PLACE OF DEATH
 (a) County Callao Registration District No. 248
 (b) Township Sheehan Primary Registration District No. 5837 Registered No.
 (c) City 0 or (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 James Vernon Sloman
 (a) Residence, No. 1111 1/2 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marjaret R. Sloman

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 17 - 1859

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>81</u>	<u>3</u>	<u>14</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill. 1

FATHER

13. NAME Geo. Sloman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky 1

MOTHER

15. MAIDEN NAME Roda Austin

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Marjaret Sloman
Fair Ground Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Pleasant Ridge DATE 3-3 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) F. B. Jones
Buffalo Mo

20. FILED 3-11 1940 Mrs. N. Sheumaker
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-1 1940

22. I HEREBY CERTIFY, That I attended deceased from Nov, 1939, to 3-1-, 1940
 I last saw him alive on 3-1-, 1940 Death is said to have occurred on the date stated above, at 2 P m.
 The principal cause of death and related causes of importance were as follows:
Arterio Sclerosis
94%
 Other contributory causes of importance:
Hypertension
Coronary occlusion

Name of operation None Date of
 What test confirmed diagnosis? usual 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) Geo. Sheumaker M. D.
 (Address) Buffalo Mo.

Date of onset unknown
2-29-40

RECEIVED

Public Health Officer No. 7,

Public File Number H-40-610

Date Filed 4-9-40

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.