

APR 23 1940

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

12259
Do not use this space.

1. PLACE OF DEATH

(a) County ST. FRANCIS Registration District No. 33
(b) Township RANDOLPH Primary Registration District No. 6024B
(c) City LEADWOOD (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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 ROY ERVING SLADE

(a) Residence, No. _____ 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) SINGLE
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2/1/40
7. AGE YEARS 0 MONTHS 1 DAYS 29 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
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) LEADWOOD (STATE OR COUNTRY) MO

FATHER 13. NAME ROY SLADE

14. BIRTHPLACE (CITY OR TOWN) MO (STATE OR COUNTRY) D

MOTHER 15. MAIDEN NAME DOROTHY WARREN

16. BIRTHPLACE (CITY OR TOWN) MO (STATE OR COUNTRY) D

17. INFORMANT ROY SLADE (ADDRESS) LEADWOOD MO

18. BURIAL, CREMATION, OR REMOVAL PLACE LEADWOOD DATE 3/31 1940

19. FUNERAL DIRECTOR J. S. BOYER, Son (ADDRESS) LEADWOOD MO

20. FILED 410 19 40 McCurbecher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-30 1940

22. I HEREBY CERTIFY, That I attended deceased from 3/20 1940, to 3/30 1940. I last saw him alive on 3/30 1940. Death is said to have occurred on the date stated above, at 10:58 a.m. The principal cause of death and related causes of importance were as follows:

Bronchial pneumonia
Date of onset 3/24/40

Other contributory causes of importance: malnutrition

Name of operation _____ Date of _____
What test confirmed diagnosis? None Was there an autopsy? _____

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) John W. Hunt, M. D.
761 (Address) Leadwood 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.

X12004

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STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18259

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 33

Primary Registration District No. 602413

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County St. Francois
(b) City or town Randolph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Roy Erwin Glade

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day _____ min.
1 29

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5/14-1940 W. E. Aubuchon (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 3 day 20
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia
Due to Corynebacterium gold possibly at service 2 weeks
Due to not known

Other conditions _____ (Include pregnancy within 3 months of death)

malnutrition

Major findings: _____

Of operations _____

Of autopsy _____

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 John W. Hunt _____ (M. D. or other)

Address Leadwood _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1940
S-12259