

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29985

State File No.

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 217

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Rural - Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Hosp. # 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr, 7 mo, 22 da
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Newton
(c) City or town Fairview
(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.

3. (a) PRINT FULL NAME Ida Slaughter - 42

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Hart Slaughter 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased 7 mar 14 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 5 11 hr. _____ min.

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

10. Usual occupation H wif

11. Industry or business _____

12. Name Porter Cumber

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

14. Maiden name Marta Russell

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

16. (a) Informant #3 Hosp - record
(b) Address Nevada, Mo

17. (a) Removal (b) Date thereof 8 25 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springdale, Ark.

18. (a) Signature of funeral director Callison & Pigg
(b) Address Springdale, Ark.

19. (a) Aug 25 1940 (b) Ida Slaughter
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25
year 1940 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from Jan 3
_____, 1939, to Aug 25, 1940

that I last saw her alive on Aug 24, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic myocardial insufficiency
Due to General arterio sclerosis
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

Duration
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?
795
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature F L Martini (M. D. or other) _____
Address St Hosp # 3 Date signed 8/25/40

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

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RECEIVED

District Health Officer No. 7,

District File Number 9-40-1268

Date Filed 9-5-40

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 Maurice Russell

Licensed Embalmer No. 2544

P. O. Address Springdale Ark

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.