

Registration District No. 461

Primary Registration District No. 3024

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Lafayette
 (c) Name of hospital or institution: 6th St.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 In this community Life
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette
 (c) City or town 6th St.
 (d) Street No. _____
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME ALFRED SLAUGHTER

3. (b) If veteran, name war _____ 3. (c) Social Security No. 287-12-8480

4. Sex Ma 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louise Powell 6. (c) Age of husband or wife if alive 49 years

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

8. AGE: Years abt. 62 Months _____ Days _____ If less than one day hr. _____ min _____

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

10. Usual occupation Miner (coal)

11. Industry or business _____

12. Name William Slaughter

13. Birthplace Not Tinsboro (City, town, or county) (State or foreign country)

14. Maiden name Cora Jackson

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

16. (a) Informant Edward Slaughter

(b) Address Lexington, MO

17. (a) Burial (b) Date thereof Oct. 22-1940 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, MO

18. (a) Signature of funeral director Winfred C. ...

(b) Address Lexington, MO

19. (a) Oct 22 (b) Nelia Bates (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 21 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Oct 21, 1940, to Oct 21, 1940,

that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Crushed skull

Due to mangled body

Due to Carom's Case

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy /

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence _____

(c) Where did injury occur? Lafayette, MO (City or town) (County) (State)

(d) Did injury occur in or about home, or farm, or industrial place, in public place? Hit by New Pacific freight While at work? _____ (Specify type of place) (e) Means of injury freight train

23. Signature J. H. ... (M. D. or other) Address Oxford, MO Date signed 10/21/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

207B-
20

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.....

Was not embalmed.

....., 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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35675-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **461**

Primary Registration District No. **3024**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Lafayette**
(b) City or town **Lickington Mo**
(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
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Alfred Slaughter**
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **m** 5. Color or race **col** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **abt 62** Months Days If less than one day hr min

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) (Date received local registrar) (b) (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

20. DATE OF DEATH: Month **Oct** day **21** 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

**Crushed skull
mangled body**

Coroner Case

Other conditions (Include pregnancy within 3 months of death)
pedestrian
Major findings: operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **acc**
(b) Date of occurrence **Lickington Mo**
(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?
hit by mo pac train
While at work (Specify type of place) (e) Means of injury

23. Signature **E. B. ...** (M. D. or other)
Address **Odessa** Date signed

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL REPORT

