

REG. JAN 25 1941 174
Registration District No. 174

Primary Registration District No. 5742

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Chariton
(b) City or town Marceline (Rural)
(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 36 years, months or days _____ (Specify whether)

3. (a) PRINT FULL NAME Mary Jennie Slaughter
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Wm Slaughter 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 25 1871
(Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace Chariton Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____
12. Name Wm M Riley
13. Birthplace Gallatin Co Ill
(City, town, or county) (State or foreign country)
14. Maiden name Mary S Breez
15. Birthplace Chariton Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gladys Slaughter
(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Dec 19 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rocke Cemetery

18. (a) Signature of funeral director James Madgley
(b) Address Marceline Mo

19. (a) 1270 40 (b) L. D. Strallon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Chariton
(c) City or town Marceline (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. Clarke Twp.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 17
year 1940 hour 10 minute 10 M.

21. I hereby certify that I attended the deceased from Dec. 16, 1940, to _____, 1940; that I last saw her alive on Dec. 16, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of liver and biliary passages

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations no op.
Of autopsy no autopsy
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? _____

(Specify type of place) _____
(e) Means of injury _____
23. Signature John W. Wilkin (M. D. or other) MD
Address Marceline Mo Date signed 12/20/40

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.

46

RECEIVED
District Health Officer No. 8,
District File Number 1-14-41
Date Filed

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 Blanche McLaughlin
Licensed Embalmer No. 1909
P. O. Address Marceline

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 42141

Registration District No. 174

Primary Registration District No. 5242

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Clarke
(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 _____
years, months or days

3. (a) PRINT FULL NAME Mary Jennie Slaughter

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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 69 Months 10 Days 22 If less than one day _____ 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) _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 17 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 _____ and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of liver and Biliary passages

Due to Primary in liver, so far as symptoms indicated. Duration about a year. No surgery or autopsy.

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

Major findings: Of operations 46 Of autopsy _____

Duration
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) Means of injury _____

23. Signature John W. Adams (M. D. or other) _____
Address Marceline Mo Date signed 7/17/41

SUPPLEMENTARY

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

A

1940
S-42141

1940
S-42141

1940
S-42141