

Registration District No. 125Primary Registration District No. 3009Registrar's No. 34

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Cape Girardeau
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Home - 527 2nd Street 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 24 years
 years, months or days

3. (a) PRINT

FULL NAME William A. Sledge3. (b) If veteran,
name war _____3. (c) Social Security
No. _____

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Hattie (Osgood)
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 17th 1890
 (Month) (Day) (Year)

8. AGE: Years 71 Months 10 Days _____
 If less than one day hr. _____ min. _____

9. Birthplace MT VERNON Illinois
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Sledge13. Birthplace Illinois
(City, town, or county) (State or foreign country)14. Maiden name Brookman15. Birthplace Illinois
(City, town, or county) (State or foreign country)16. (a) Informant Ralph Ward(b) Address 527 2nd Street Cape17. (a) Burial (b) Date thereof 1-19-41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Waynes Cemetery(a) Signature of funeral director John J. ...(b) Address Cape Girardeau Mo19. (a) 1-17-41 (b) J. M. Thompson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape
 (c) City or town Arbar
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 1
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 17
 year 1941 hour 11:20 minute _____ P. M.

21. I hereby certify that I attended the deceased from 1939
 _____, 19____, to 1-17-41, 1941;
 that I last saw him alive on 1-17-41, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death.

Chr. Myocarditis
Atrial Fibrillation

Due to _____

Due to _____

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) _____

(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? _____

(a) Signature D. B. Good (Specify type of place) _____
 (b) Address Cape Girardeau Mo (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address Cape Girardeau Mo Date signed _____

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

W. H. Ester

....., Registered Apprentice No.

working under my personal supervision.

Signed *W. H. Ester*

Licensed Embalmer No. *3568*

P. O. Address *Cape Girardeau*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 2095-

Registration District No. 125-

Primary Registration District No. 3009

Registrar's No.

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

ROWENA MOORE

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Gir
(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 Wm A Sledge

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 wd

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Mar - 17 - 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>10</u>		hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-28-41 (b) J. M. Thompson
(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 17
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that Wm A Sledge was alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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) _____

(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)

(a) Means of injury _____

23. Signature A. B. Elrod (M. D. or other)

Address Cape Girardeau Date 3-28-41

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

