No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
U OF THE CENSUS

11 1941

District No. 461

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5623

State File No. 42

Registrar's No. 25417

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

1. PLACE OF DEATH:
(a) County: Lafayette
(b) City or town: Rural Lexington Twp
(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 years, months or days)
In this community: Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Lafayette
(c) City or town: Lexington Twp Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: Rural Lexington Twp
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: —

3. (a) PRINT FULL NAME: Nathaniel Slaughter
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Male
5. Color or race: Col.
6. (a) Single, widowed, ~~married~~, divorced: Single
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: About 69 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
69	—	—	hr. ..... min.

9. Birthplace: not known. (City, town, or county) (State or foreign country)
10. Usual occupation: Coal Miner
11. Industry or business: Mining
FATHER
12. Name: —
13. Birthplace: (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: —
15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: Carrie Lucas
(b) Address: Lexington Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 14-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Grove
18. (a) Signature of funeral director: Greenstone
(b) Address: Lexington, Mo
19. (a) Aug 6 (Date received by local registrar) (b) Delia Bates (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 1941 hour 7 30 P. M. minute — M.
21. I hereby certify that I attended the deceased from June 25 1941, to July 12 1941, that I last saw him alive on July 11 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Apoplexy — Duration 24 hrs
Due to: Cerebral Hemorrhage 7/11/41
Due to: 830
Other conditions: —
(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

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? — (Specify type of place)
While at work: — (e) Means of injury: —
23. Signature: L. S. West, (M. D. ~~or other~~) D
Address: Lexington, Mo. Date signed: 7/12/41

570

(Licensed Embalmer's Statement on Reverse Side)

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

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 William Henley

Licensed Embalmer No. 3405

P. O. Address Lexington Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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

S. No. 2B
1—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25417

Registration District No. 461 — Primary Registration District No. 5625 — Registrar's No. 42

1. PLACE OF DEATH:

(a) County: Lafayette

(b) City or town: Rural Lexington twp
(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 years, months or days)
In this community .....

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) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Nathaniel Slaughter

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: M

5. Color or race: C

6. (a) Single, widowed, married, divorced: S

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: ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name: Shot Lincoln

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

14. Maiden name: Not known

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

16. (a) Informant .....
(b) Address .....

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

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) Aug 6/41 (Date received local registrar) (b) Nelia Bates (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July ..... Day: 2 ..... year: 1941 ..... 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 ..... Duration

Due to .....

Due to .....

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

Major findings:
Of operations .....

Of autopsy .....

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)
(b) 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 ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

S-25417