

Registration District No. 799

Primary Registration District No. 4479

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Slater
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
403 N. Broadway
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether
In this community 50 years years, months or days)

3. (a) PRINT FULL NAME Mary Chloris Land

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

4. Sex Female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife J.B. Land 6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased Aug. 3 1863
(Month) (Day) (Year)

8. AGE: Years 78 Months 0 Days 1 If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business

12. Name Joab Spencer

13. Birthplace N.H.
(State or foreign country)

14. Maiden name Mary Hufferker
(State or foreign country)

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

16. (a) Informant J.B. Land

(b) Address Slater Mo.

17. (a) Burial (b) Date thereof 8 6 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Slater Mo.

18. (a) Signature of funeral director Hill Brothers

(b) Address Slater Mo.

19. (a) 8-5-41 (b) Ella Alexander
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline
(c) City or town Slater
(If outside city or town limits, write "RURAL")
(d) Street No. 403 N. Broadway
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3
year 1941 hour 2 minute 25 P.M.

I hereby certify that I attended the deceased from July 15, 1941 to Aug 3rd, 1941.
that I last saw her alive on Aug 13rd, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris Duration 2 hrs.

Due to Coronary Occlusion with Sclerosis (Left) 2 yrs

Due to Chronic Myocarditis 6 mo.

Other conditions none

Major findings: Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following: none

(a) Accident, suicide, or homicide (specify) none

(b) Date of occurrence none

(c) Where did injury occur? (City or town) (County) (State) none

(d) 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 none

23. Signature W.A. & Lactwood (M. D. or other) MD

Address Slater Mo Date signed 8/5/41

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

MOTHER FATHER

97
2
1

47
1

0

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 21 1943
OCT 20 1943

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-11-41

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. 1292,
working under my personal supervision.

Signed Sam M. Hill

Licensed Embalmer No. 1292

P. O. Address Slate Mo

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.