V. S. No. 2
50M—5-42
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17152

FILED JUN - 1943

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2208

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3601 Wabash 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX (Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3601 Wabash 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME LEWIS SLOMAN

3. (b) If veteran, name war No

3. (c) Social Security No. 494-14-2949

4. Sex Male 0

5. Color or race Wh

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Ethel May Sloman

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased November (Month) 9, (Day) 1863 (Year)

8. AGE: Years 79 Months 6 Days 2 If less than one day hr. min.

9. Birthplace New York City (City, town, or county) N.Y. 1 (State or foreign country)

10. Usual occupation Retired Manager

11. Industry or business B.P.O.Elks Lodge #26

FATHER
12. Name Sam Sloman 4
13. Birthplace London (City, town, or county) England 1 (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace London (City, town, or county) England 4 (State or foreign country)

16. (a) Informant Mrs. Ethel M. Sloman
(b) Address 3601 Wabash

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-43 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director J W Wagner
(b) Address Kansas City, Mo.

19. (a) 5-12-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11th
year 1943 hour 8:00 minute A. M.

21. I hereby certify that I attended the deceased from 1-14, 1943, to 5-11, 1943;
that I last saw him alive on 5-11, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis with retention of none.

Due to General arteriosclerosis.

Due to Paradoxical Incontinence - Terminal, Red sores with retrocession

Other conditions
(Include pregnancy within 3 months of death)

131 13

Major findings:
Of operations None.

Of autopsy None.

Duration

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) no
(b) Date of occurrence 0
(c) Where did injury occur? 0 (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 Wilson A Myers. 0 (M. D. or other)
Address Kansas City Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

5263

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 A. R. Hauenschild

Licensed Embalmer No. 4159

P. O. Address Kansas City 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.