

FILED DEC 27 1943

Registration District No. **2283** Primary Registration District No. **2000**

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

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **SPRINGFIELD MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1907 TRAVIS / AVE.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE 39**
(c) City or town **SPRINGFIELD MO.**
(If outside city or town limits, write "RURAL")
(d) Street No. **1907 TRAVIS AVE S**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **WILLIAM THOMAS SLOAN**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **SUZANNE SLOAN** 6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **NOV. 8 1863**
(Month) (Day) (Year)

8. AGE: Years **80** Months **1** Days **7** If less than one day hr. min.

9. Birthplace **MILLER Co. MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired (10yr) R.R. Clerk**

11. Industry or business **Retired Clerk in R.R. Store Room**

MOTHER FATHER

12. Name **Isaac Sloan**

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

14. Maiden name **Jones**

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

16. (a) Informant **Suzanne Sloan**
(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (b) Date thereof **Dec. 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **East Lawn Cemetery**

18. (a) Signature of funeral director **J. W. Hingert & Co.**
(b) Address **SPRINGFIELD MO.**

19. (a) **12-18-43** (b) **O. W. Handberg**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC.** day **15th**
year **1943** hour **10** minute **18 A. M.**

21. I hereby certify that I attended the deceased from **12-12-43**, 19... to **12-15-43**, 19...
that I last saw him alive on **12-10-43**, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death **Regenerative Heart Disease**
Anemia

Duration
2 yrs.
2 wks.

Due to **Senility**

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)

(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.....

23. Signature **Simpson** (M. D. or other).....

Address **Springfield, Mo.** Date signed **12-18-43**

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.....
.....
working under my personal supervision.

Signed..... *May Rhodes*
Registered Apprentice No.....
Licensed Embalmer No..... *4071*
P. O. Address..... *Springfield*

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.

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1019

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME William Thomas Sloan

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

4. Sex _____ 5. Color or race _____
6. (a) Single, widowed, married, divorced _____
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 _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____ Chronic Nephritis

Due to _____

Other conditions _____ (Include pregnancy within 5 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) (e) Means of injury _____

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

Address Springfield, Mo Date signed _____

SUPPLEMENTARY

Duration 2 yrs
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

S-42332