

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1737

FILED JAN 19 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5663

## 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:  
4310 Jarboe 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 2 months years, months or days)

3. (a) PRINT FULL NAME Ratie Sloggett3. (b) If veteran, name war no 3. (c) Social Security No. no4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Wid6. (b) Name of husband or wife James Sloggett 6. (c) Age of husband or wife if alive \_\_\_\_\_ years6. Birth date of deceased Aug 25 1878  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
65 68 4 3 hr. \_\_\_\_\_ min.9. Birthplace England  
(City, town, or county) (State or foreign country)10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Thomas Greenstade13. Birthplace England  
(City, town, or county) (State or foreign country)14. Maiden name Ann Hull15. Birthplace England  
(City, town, or county) (State or foreign country)16. (a) Informant Mrs Ravis Pittier  
(b) Address 4310 Jarboe17. (a) Removal (b) Date thereof 1-7-44  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Santa Monica, Calif18. (a) Signature of funeral director Mrs C K Foster(b) Address 918 Brooklyn N.C. Mo19. (a) Dec 31 1943 (b) J E Brown  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State California (b) County Los Angeles 991  
 (c) City or town Santa Monica  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1820 - 22 St  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28  
year 1943 hour 8 minute 40 P. M.21. I hereby certify that I attended the deceased from Nov 1, 1943  
19. to Dec 28 19. 43  
that I last saw her alive on Dec 28 19. 43  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Coronary thrombosis</u>	<u>30 min</u>
Due to <u>Atheroma</u>	<u>20 days</u>
Due to _____	_____

Other conditions Chronic atherosclerosis  
(Include pregnancy within 3 months of death)

pericarditis & pleurisy  
Chronic thrombosis  
descending coronary artery  
 Of autopsy: 3. Old myocardial infarct - etc see above

## 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 Barick Wilson (M. D. or other) M.D.  
Address 1025 Rialto Bldg Date signed 12-28-43

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed... *Reigel C. Browning*

Licensed Embalmer No... *2724*

P. O. Address... *H. C. md*

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

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