

S. No. 2  
M-5-42  
5-17-39  
X328

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

11031

Registrar's No.

248

FILED MAR 27 1944

Registration District No.

28

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  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 407 W. Pacific  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 31 years. (Specify whether years, months or days)  
In this community 31 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 407 W. Pacific  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country.

3. (a) PRINT FULL NAME Albert Sleeth

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Louise Sleeth 6. (c) Age of husband or wife if alive unk. years  
7. Birth date of deceased August 3 1859  
(Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 12 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business Restaurant Operator

MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Sleeth  
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof March 20, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director H.H. Loomeyer  
(b) Address Springfield, Mo.

19. (a) 3-18-44 (b) S. W. Lindley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15  
year 1944 hour 3 minute 20 P.M.

21. I hereby certify that I attended the deceased from 3-1-44  
to 3-15-44, 1944,  
that I last saw him alive on 3-15, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Coro. Renal-Vascular  
Disease

Duration 1 yr.

Due to

Due to

Other conditions 12/10  
(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?

(Specify type of place) (Specify means of injury)  
While at work? Yes  
23. Signature Max Lyle (M. D. or other) M.D.  
Address Springfield, Mo. Date signed 3-16-44

984

(Licensed Embalmer's Statement on Reverse Side)

W

**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 L. Soohi Gorman

Licensed Embalmer No. 3177

P. O. (Address) Springfield 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.**