

Registration District No. **FILED APR 28 1944**

Primary Registration District No. **3071**

Registrar's No. **7**

1. PLACE OF DEATH:
(a) County **Saline County**
(b) City or town **Slater**
(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
In this community **more than 40 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Saline**
(c) City or town **Slater**
(d) Street No. **309 West Main St**
(e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **William George Eggleston**
(b) If veteran, name war **✓**
(c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **03** day **11**
year **1944** hour **9** minute **55** P.M.

4. Sex **Male** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **2 divorced**
6. (c) Age of husband or wife if alive **2** years

21. I hereby certify that I attended the deceased from **19** to **3-11** **1944**
that I last saw him alive on **3-11** **1944**
and that death occurred on the date and hour stated above.

7. Birth date of deceased: **December 10 - 1849**
(Month) (Day) (Year)

Immediate cause of death **Thrombia**
Duration **7 days**

8. AGE: Years **94** Months **3** Days **1**
If less than one day hr. min.

Due to **Acute Pharyngitis**
Due to **Generalized Osteomyelitis**

9. Birthplace **Near Middleburg, Virginia**
10. Usual occupation **Retired Merchant**
11. Industry or business

Other conditions
Major findings:
Of operations

12. Name **W. G. Eggleston**
13. Birthplace **Baltimore, Md.**
14. Maiden name **Frances Buford**
15. Birthplace **Douglas, Mo.**

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant **Mrs. Frances Eggleston**
(b) Address **Slater, Mo.**
17. (a) Burial, cremation, or removal **Slater, Mo.**
(b) Date thereof **3-12-44**
(c) Place: burial or cremation **Slater City Cemetery**
18. (a) Signature of funeral director **James A. Stager**
(b) Address **Slater, Mo.**
19. (a) 3-19-44 **(b) Mrs. John A. Stager**
(Date received local registrar) (Registrar's signature)

23. Signature **O. A. McJannet, M.D.**
Address **Slater, Mo.** **Date signed** **3-20-44**

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

4-14-44

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.

Registered Apprentice No.

Signed

Licensed Embalmer No.

P. O. Address

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. april
Registrar's No. 7

Registration District No. 322 Primary Registration District No. 3071

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Saline
(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 _____
years, months or days

3. (a) PRINT FULL NAME Wm George Eggleston

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 10 1944
(Month) (Day) (Year)

8. AGE: Years 94 Months 5 Days _____ If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (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 March Day 11 Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Myocardial Infarction
Generalized arteriosclerosis
acute Pharyngitis
Generalized arteriosclerosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 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 A. M. Sweeney (M. D. or other) _____ Date signed _____

SUPPLEMENTAL

TEMPORARY

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

MOTHER FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

12264