No. 2
-8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 10 1944

Registration District No. 294

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3056

State File No. 28602

Registrar's No. 168

**1. PLACE OF DEATH:**

(a) County Randolph

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

(c) Name of hospital or institution: McCormick Hospital 0
(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 Missouri (b) County Randolph 88

(c) City or town Moberly 6 3
(If outside city or town limits, write "RURAL")

(d) Street No. So Morley
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country ..... 0

3. (a) PRINT FULL NAME Johnie Slaughter

3. (b) If veteran, name war ✓

3. (c) Social Security No. 491-07-0290

4. Sex Male

5. Color or race White 0

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

6. (b) Name of husband or wife Mary Slaughter

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

7. Birth date of deceased April (Month) 23rd (Day) 1893 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 3 | 10 | ..... hr. ..... min. |

9. Birthplace ..... (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Truck Driver

11. Industry or business Self

FATHER
12. Name John T. Slaughter
13. Birthplace ..... (City, town, or county) Ky / (State or foreign country)

MOTHER
14. Maiden name Sarah Gentry
15. Birthplace ..... (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Mrs Mary Slaughter
(b) Address Moberly Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug (Month) 6 (Day) 1944 (Year)
(c) Place: burial or cremation Moberly

18. (a) Signature of funeral director Mahan and Son
(b) Address Moberly

19. (a) 8-6-44 (Date received local registrar) (b) Irma Nave (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 3rd year 1944 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 1st, 1944, to Aug 3rd, 1944 that I last saw him alive on Aug 2nd, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Brights Disease

Due to .....

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) .....

(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)

While at work? ..... (e) Means of injury .....

23. Signature M. E. Ensley (M. D. or other)

Address Moberly Mo. Date signed 8-6-44

1036

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-44-1554
Date Filed SEP 8 1944

## 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 Frank D. Witt

Licensed Embalmer No. 3021

P. O. Address Moberly 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.**

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

**1. PLACE OF DEATH:**

(a) County Randolph

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

(c) Name of hospital or institution: McCormick Hosp
(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 ..... (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 .....

**3. (a) PRINT FULL NAME** John Slaughter

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 M

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

7. Birth date of deceased April (Month) 23 (Day) 1893 (Year)

**8. AGE:** Years 51 | Months 3 | Days 10 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Truck Driver

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

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

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month Aug day 3
year 1944 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... , 19..., to ..... , 19.....;
that I last saw h..... alive on ..... , 19.....;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Brights Disease Chronic | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations .....
Of autopsy .....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

**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) .....

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(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)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

286602