

FILED NOV 2 1944

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1060

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Joseph

(c) Name of hospital or institution: State Hospital # 2  
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution Employer  
(Specify whether years, months or days)

In this community 4 yrs 5 2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew

(c) City or town Rural Roseville  
(If outside city or town limits, write "RURAL")

(d) Street No. 7  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Aver y Abraham Slater

3. (b) If veteran, name war No

3. (c) Social Security No. 481-12-3109

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10/25 day \_\_\_\_\_  
year 1944 hour 10 minute 0 M.

4. Sex Male 5. Color White

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

6. (b) Name of husband or wife Gertude

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

7. Birth date of deceased Dec 21 1891  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10/25 1944 to 10/25 1944

that I last saw him alive on 10/25 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction Duration a few minutes

8. AGE: Years 52 Months 9 Days 4

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Probably arteriosclerosis

I had not treated him

Due to before

9. Birthplace Well felt NEBY  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Attendant State Hospital

Major findings: Of operations 94%

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

Of autopsy \_\_\_\_\_

12. Name Edd Slater

13. Birthplace Dayton Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Anderson

15. Birthplace ANDERSON CO, Mo  
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Gertude Slater

(b) Address E. C. Breit

17. (a) B (b) Date thereof 10-29-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah

18. (a) Signature of funeral director E. C. Breit

(b) Address Savannah Mo.

19. (a) 10-28-44 (b) Helena J. Pickle  
(Date received local registrar) (Registrar's signature)

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 6

23. Signature E. C. Breit (M. D. or other) \_\_\_\_\_

Address State Hospital # 2 Date signed 125 1944

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

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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.....

*E. C. Breit*

Licensed Embalmer No.....

*Savannah*

P. O. Address.....

*2650*

**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.**