

No. 4-13-40
5-17-39
PI X25159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6790**

FILED MAR 12 1945
Registration District No. 253

Primary Registration District No. 4384

Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Skidmore
(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 6 yrs. years, months or days

3. (a) PRINT FULL NAME Mary Jane Slaughter,
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Thomas B Slaughter 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar. 23, 1855
(Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife.

11. Industry or business _____

12. Name Aaron Linville

13. Birthplace Not Known
(City, town or county) (State or foreign country)

14. Maiden name Martha Totten

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant James S. Davis
(b) Address Skidmore Mo

17. (a) Burial (b) Date thereof Mar. 8, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Masonic Cemetery

18. (a) Signature of funeral director Price Funeral Home
(b) Address Maryville, Mo
19. (a) Mar 9 45 (b) Mrs John Hockenbuhl
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Nodaway
(c) City or town Skidmore
(If outside city or town limits, write "RURAL") _____
(d) Street No. _____ (If rural, give location) _____
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 5th
year 1945 hour 2 minute 05 P.M.

21. I hereby certify that I attended the deceased from Aug, 1944, to March 5, 1945; that I last saw her alive on March 5, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Rectal Carcinoma

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of _____)

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 J. V. Benton (M. D. or other) NO
Address Skidmore, Mo Date signed 3-27-45

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1383

(Licensed Embalmer's Statement on Reverse Side)

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.....

John W. Price

Licensed Embalmer No.....

4281

P. O. Address.....

Maryville 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.

Registration District No. 253 Primary Registration District No. 4284 Registrar's No. _____

1. PLACE OF DEATH:
(a) County noclaway
(b) City or town Skidmore
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Mary Jane Slaughter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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: March 23 (Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____ year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____
Rectal Carcinoma

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) _____
(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 _____ (M. D. or other) _____
Date signed 3/14/45

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

SUPPLEMENTARY

6790