. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 26 1945

Registration District No. 325

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7291

Primary Registration District No. 4479

Registrar's No. 10

1. PLACE OF DEATH:
(a) County: Schuyler
(b) City or town: Queen City
(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 years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Schuyler
(c) City or town: Queen City Mo (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: Ernest Melvin Sloop
3. (b) If veteran, name war: World War I
3. (c) Social Security No. ____
4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Freda Sloop
6. (c) Age of husband or wife if alive: 44 years
7. Birth date of deceased: Dec. (Month) 16 (Day) 1892 (Year)

8. AGE: Years	Months	Days	If less than one day
52	1	25	____ hr. ____ min.

9. Birthplace: Queen City (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Garage work
11. Industry or business: " "
12. FATHER Name: Nicholas Sloop
13. FATHER Birthplace: New Market Marion Co Mo (City, town, or county) (State or foreign country)
14. MOTHER Maiden name: Alelia Knittle
15. MOTHER Birthplace: (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Orsil L. Sloop.
(b) Address: Queen City
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: Feb. 14, '45 (Month) (Day) (Year)
(c) Place: burial or cremation: Queen City cemetery
18. (a) Signature of funeral director: Wm H West
(b) Address: Queencity Mo
19. (a) Feb 14, 1945 (Date received local registrar) (b) C. C. Justice (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 year 1945 hour 10 minute 30 P.M.
21. I hereby certify that I attended the deceased from Jan 1941, 19.41, to Feb 11, 1945, that I last saw him alive on Feb 11, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Central nervous system syphilis	2 yrs
Due to: Syphilis tertiary	4 yrs
Due to:	
Other conditions (Includes 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)
While at work? (e) Means of injury
23. Signature: O. P. Gum (M. D. or other) D.O.
Address: Queen City Date signed: Feb 12

1278

(Licensed Embalmer's Statement on Reverse Side)

FEB 26 1945

MAR - 6 1945

RECEIVED
District Health Office No. 10
District File Number 2-45-378
Date Filed FEB 23 1945

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 Self

, Registered Apprentice No. ,

working under my personal supervision.

Signed Wm N West

Licensed Embalmer No. 2882

P. O. Address Queencity 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.