

No. 2  
-8-43  
-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

**FILED MAR 8 1945**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12751**  
Registrar's No. **65**

Registration District No. **15** Primary Registration District No. **5070**

1. PLACE OF DEATH:

(a) County **Barton**  
(b) City or town **Milford Twp**  
(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 **16 yrs** (Specify whether years, months or days)  
In this community **16 yrs**

3. (a) PRINT **LEMUEL G. SLATES**  
FULL NAME

3. (b) If veteran, name war: \_\_\_\_\_ 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 **Mercy Slates** 6. (c) Age of husband or wife if alive **73** years

7. Birth date of deceased **Oct. 22nd, 1868**  
(Month) (Day) (Year)

8. AGE: Years **76** Months **1** Days **23** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Kilgore, Ohio**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

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

12. Name **Wm Slates**

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

14. Maiden name **Phoebe Stewart**

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

16. (a) Informant **Carl Slates**

(b) Address **Lamar, MO.**

17. (a) **Burial** (b) Date thereof **Dec 16th, 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Howell Cemetery**

18. (a) Signature of funeral director **G.B. Beeny & sons**  
**Sheldon, MO.**

(b) Address \_\_\_\_\_

19. (a) **12-16-44** (b) **Martha River**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barton**  
(c) City or town **Sheldon**  
(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 **Dec** day **14th**  
year **1944** hour **3** minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from **3-15** 19**43** to **12-14** 19**44**

that I last saw h. \_\_\_\_\_ alive on **10-28-44**, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Rectum**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: **46d**  
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 **W.H. Engreston - D.O.** (M. D. or other)  
**Sheldon, MO.** Date signed **12-15-44**

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

MOTHER FATHER

1179

(Licensed Embalmer's Statement on Reverse Side)

*Hand for signature*

MAY 4 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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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. 15

Primary Registration District No. 5070

Registrar's No. 650

1. PLACE OF DEATH:

(a) County Barton  
(b) City or town milford mo  
(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 Samuel C. Slater

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 \_\_\_\_\_ year

7. Birth date of deceased oct 22 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, \_\_\_\_\_ min.)

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

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 \_\_\_\_\_ (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 Dec Day 14 year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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 \_\_\_\_\_

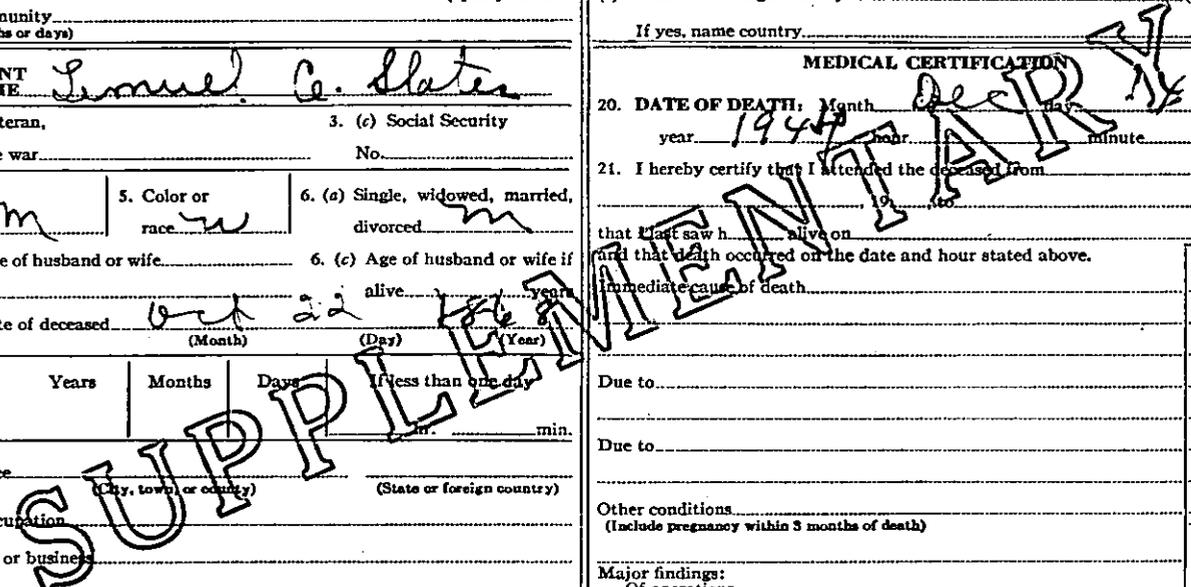
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(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 W. H. Eggleston (M. D. or other) MD

Address \_\_\_\_\_ Date signed \_\_\_\_\_



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

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

12791