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v. 5-17-39
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#35289

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 21 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15595

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4175

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2months. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4350 Maryland
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Arthur Slack

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Carrie M. Slack

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased December (Month) 24 (Day) 1878 (Year)

8. AGE:

Years	Months	Days	If less than one day
66	4	15	hr. min.

9. Birthplace Wayne County (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Retired

11. Industry or business

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

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

16. (a) Informant Loretta Drysdale
(b) Address 2831a N. 14th St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-11-45 (Month) (Day) (Year)
(c) Place: burial or cremation Fairfield, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) MAY 10 1945 (Date received local registrar) (b) J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th year 1945 hour 3:20 minute P. M.

21. I hereby certify that I attended the deceased from Mar 8, 1945 to 5/9/45, 19..; that I last saw him alive on 5/9/45, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis Agitans

Due to

Due to

Other conditions Fracture of Neck of Femur
(Includes pregnancy within 3 months of death)

Major findings: Injury did not contribute to cause of death
Of operations
Of autopsy

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 10-18-44

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In house (Specify type of place)

While at work? (e) Means of injury Fall

23. Signature James C. Shy M.D. (M. D. or other)

Address 1515 Lafayette 5/9/45 Date signed

(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 Ogonacki

Licensed Embalmer No. 2398

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.