

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

277779

FILED AUG 22 1945

State File No. ....

Registration District No. ....

Primary Registration District No. 3036

Registrar's No. 79

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Aurora  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution Hosp 1 day  
(Specify whether years, months or days)

In this community 1  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry 5

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

(d) Street No. R.F.D. # 1 Crane Mo.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME Cecil Sledge

3. (b) If veteran, name war .....

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24  
year 1945 hour 4 minute 25 P.M.

4. Sex Male ( ) 5. Color or race White

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

6. (b) Name of husband or wife Elsie Sledge

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased June 5 1903  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 24  
1945 to July 24 1945

that I last saw him alive on July 24  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>42</u>	<u>1</u>	<u>19</u>	hr. min.

Immediate cause of death Coronary Thrombosis 20 min  
Duration

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

Due to Cellulitis at axilla

Due to Teich's bite infection  
nature not determined 3 day

Other conditions (include pregnancy within 3 months of death)

10. Usual occupation Line Man

11. Industry or business Empire Dist Elec Co

Major findings:  
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of autopsy .....

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

12. Name W.F. Sledge

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

14. Maiden name Rosealee Perriman

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

16. (a) Informant Mrs Elsie Sledge

(b) Address R # 1 Crane Mo

17. (a) Burial (b) Date thereof 7/27/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mars Hill

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? .....

18. (a) Signature of funeral director J.F. King

(b) Address Aurora Mo.

While at work?                      (Specify type of place) (c) Means of injury .....

23. Signature R.A. Lowman (M. D. or other)                     

Address Aurora Date signed 7/24/45

19. (a) 7-96-45 (b) Cunice  
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 6

District File Number

845-895

Date

AUG 20 1945

JAN 10 1946

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

*Herman Surridge*

Licensed Embalmer No.

3072

P. O. Address

Aurora 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept  
Registrar's No. 79

Registration District No. 175

Primary Registration District No. 3036

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Wardsburg  
(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

Cecil Sledge

3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 5 (Month) (Day) (Year)

8. AGE: Years 42 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min.

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

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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1945 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to Rocky mt spotted fever not diagnosed

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

Major findings: Of operations \_\_\_\_\_ Of autopsy g40

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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_ Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

JAN 21 1946

S-27779

JAN 10 1946