. S. No. 2
M—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

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 19 1945

State File No. 32378

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8812

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Park Lane Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 3236 Morganford Rd (If rural, give location) 16 9

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Joseph Slinger

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 0

5. Color or race Whiten

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

6. (b) Name of husband or wife Gladys

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased August (Month) 16 (Day) 1910 (Year)

8. AGE: Years 35 Months 2 Days 24 If less than one day hr. min.

9. Birthplace St. Louis Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Foreman

11. Industry or business Blanke Baer Pres Co

FATHER
12. Name Robert Slinger
13. Birthplace St. Louis Mo (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Margaret Hahn
15. Birthplace St. Louis Mo (City, town, or county) 0 (State or foreign country)

16. (a) Informant Gladys Slinger

(b) Address 3236 Morganford Rd

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (Month) 13 (Day) 45 (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director Kriegshauser

(b) Address 4228 So. Kingshighway

19. (a) OCT 12 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10 year 1945 hour 1.05 AM minute M.

21. I hereby certify that I attended the deceased from October 8, 1945, 19 to October 10, 1945 19 that I last saw him alive on October 9, 1945 19 and that death occurred on the date and hour stated above.

Immediate cause of death Obstruction of the bowels. Duration

To my knowledge, October 8, 1945.

Due to Volvulus

Due to

Other conditions General Peritonitis. As above. (Include 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 D C Rainer M.D. (M. D. or other)

Address 320 Metropolitan Bldg. Date signed 10/11/45

(Licensed Embalmer's Statement on Reverse Side)

Dr Smith Parklane Hosp

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 Edwin D. Mc Dermott

Licensed Embalmer No. 3024

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.