

FILED OCT 24 1945

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1078

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

1. PLACE OF DEATH:  
 (a) County Buchanan  
 (b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 Mo. Methodist Hosp. 21 days  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 21 days  
(Specify whether years, months or days)  
 In this community 15 years

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Buchanan  
 (c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 415 North 7th  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Alexander J. Slater

3. (b) If veteran, name war none  
 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 Lena Slater  
 6. (c) Age of husband or wife if alive Not stated years

7. Birth date of deceased: May 28 1871  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	4	8	hr. min.

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

10. Usual occupation custodian

11. Industry or business Geiger Apts.

MOTHER FATHER {  
 12. Name James Slater  
 13. Birthplace Glasgow Scotland  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary Russell  
 15. Birthplace Glasgow, Scotland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lena Slater  
 (b) Address 415 North 7th

17. (a) burial (b) Date thereof 10/9/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah, Mo.

18. (a) Signature of funeral director [Signature]  
 (b) Address 319 So. 10th

19. (a) 10-9-1945 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6th  
 year 1945 hour 2 minute 25 A. M.

21. I hereby certify that I attended the deceased from Sept 15 1942 to Oct 6 1945;  
 that I last saw him alive on Oct 5 1945;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Central Hemorrhage 2/dec

Due to Coronary Arteriosclerosis

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

Other conditions Diabetes Mellitus  
(Include pregnancy within 3 months of death)

PHYSICIAN  
 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 [Signature] (M. D. or other) \_\_\_\_\_  
 Address 620 Truman St Date signed 10-5-45

Dr. J. L. Howden

**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 Gerald I. Wade

Licensed Embalmer No. 4172

P. O. Address St. Joseph

**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.**