

BUREAU OF VITAL RECORDS
FILED DEC 28 1945

STANDARD CERTIFICATE OF DEATH

State File No. 39801

11817

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Alexian Brothers Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 Days
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT John H. Slaughter
FULL NAME3. (b) If veteran, No. _____ 3. (c) Social Security No. _____
name war _____4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed6. (b) Name of husband or wife Leona 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased March 4 1866
(Month) (Day) (Year)8. AGE: Years 79 Months 9 Days 7 If less than one day hr. _____ min. _____9. Birthplace Marianna Arkansas
(City, town, or county) (State or foreign country)10. Usual occupation Retired

11. Industry or business _____

12. Name Unknown13. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown
(City, town, or county) (State or foreign country)16. (a) Informant Ira G. Slaughter(b) Address 4075 Giles Ave.17. (a) Burial (b) Date thereof Dec. 14, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation New St. Marcus Cemetery18. (a) Signature of funeral director Walter R. Bledsoe(b) Address 3634 Gravois Ave.19. (a) DEC 12 1945 (b) J. F. Braden
(Data received local registrar) (Registrar's signature)

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. 4075 Giles Ave.
 (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 11
year 1945 hour 7 minute 30 A. M.21. I hereby certify that I attended the deceased from 12-3-45
_____, 19____ to 12-11-45, 19____;
that I last saw him alive on 12-11-45, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death Bronchitis Pneumonia Duration 1 da.Due to Intestinal Distention with
from 12-10-45

Due to _____

Other conditions _____
(Include pregnancy within 5 months of death)Major findings: Intestinal Perforation PHYSICIAN _____

Of operations _____ Underline the cause to which death should be charged statistically.

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no.

(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 J. A. Swickard (M. D. or other) MDAddress 1935 Park Ave Date signed 12-10-45

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

Robert C. Wheeler

Licensed Embalmer No. *2128*

P. O. Address *St. Louis*

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.