

FILED

AUG 15 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 4286

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Wellington
 (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 years, months or days) 57 yrs

3. (a) PRINT FULL NAME DORA SLADE

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased March 7 1884
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 3 12 hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business self

12. Name John S. Slade O

13. Birthplace Jackson Co. Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Sarah J. Stigal

15. Birthplace Ray Co. Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Grace Slade Single

(b) Address Wellington Mo.

17. (a) Burial (b) Date thereof June 21 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery Wellington

18. (a) Signature of funeral director E. J. Ward

(b) Address Wellington Mo.

19. (a) July 1 '47 (b) John S. Slade
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
 (c) City or town Wellington
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19
 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 21 April
1947 to 19 June 1947
 that I last saw h. E.Y. alive on 19 June 1947
 and that death occurred on the date and hour stated above

Immediate cause of death Carcinomatous Duration _____

Due to _____

Due to _____

Other conditions Bronchial Pneumonia
 (Include pregnancy within 3 months of death)

Major findings: Carcinoma with
 Of operations cutaneous obstruction

Of autopsy _____

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

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

(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 John Ward (M. D. or other) MD

Address Wellington Date signed 21 June 47

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

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45
39
47870

NOV 18 1948

RECEIVED

District Health Officer No. 8

District File Number

Date Filed 8-17-47

AUG 19 1948

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 W. P. Cunn
Licensed Embalmer No. 4305
P. O. Address Wethersfield, 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.

Registration District No. 171 Primary Registration District No. 4266

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Wellington
(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 Dora Glade
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased March (Month) 19 (Day) 1904 (Year)

8. AGE: 63 Years 3 Months 10 Days (If less than one day, hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Burial, cremation, or removal) (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 Aug Year 1947 minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to _____
Due to Carcinoma of sigmoid

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 46E 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Joseph W. Wood MD (M. D. or other) _____ Address Wellington MO Date signed 1800047

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

SUPPLEMENTARY

24684