

FILED OCT 9 1947

Registration District No. **128**

Primary Registration District No. **5465**

Registrar's No. **809**

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route # 11 Box 954
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community Wilkes (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield Rural N. Campbell Township
(If outside city or town limits, write "RURAL")
(d) Street No. Route # 11 Box 954
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Larry Wayne Slavens

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

4. Sex Male 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 Sept. 27 1948
(Month) (Day) (Year)

8. AGE: Years — Months 11 Days 21 If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business.....

MOTHER FATHER { 12. Name Earl Slavens
13. Birthplace Laclede County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Martina Jones
15. Birthplace Harrison Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ruby Green
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 9/13/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 9-13-47 (b) M.E. Handley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1947 hour 10 minute 45 p.m.

21. I hereby certify that I attended the deceased from September 6
1947 to September 12, 19 47
that I last saw him alive on September 12, 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death Setony

Due to broncho-pneumonia

Due to Malnutrition

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

Major findings:
Of operations.....
Of autopsy.....
109

Duration

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 M.H. Burke M.D. (M.D. or other).....
Address 410 Madcraft Bldg. Date signed 9-13-47

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

39
0
0

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.

This body was not embalmed.

Signed.....

Licensed Embalmer No.....

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.