. S. No. 2
0M—1/47
ev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35056

FILED NOV 4 1947

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 368

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

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Residence 2301 Ford Street
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Marion 64
(c) City or town Hannibal 2
(If outside city or town limits, write "RURAL")
(d) Street No. 2301 Ford Street 4
(If rural, give location) 0
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Van Shoick Slingerland
3. (b) If veteran, name war .....
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 Henrietta Slingerland
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased October 4, 1858 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
89		21	..... hr. ..... min.

9. Birthplace Sharon New York (City, town, or county) (State or foreign country)
10. Usual occupation Carpenter
11. Industry or business Retired
FATHER
12. Name Dan Slingerland
13. Birthplace Sharon New York (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Martha
15. Birthplace Sharon New York (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Grace Hill
(b) Address 2301 Ford Street, Hannibal
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Olivet
18. (a) Signature of funeral director W. Crawford Smith
(b) Address 902 Broadway Hannibal Missouri
19. (a) 10-28-47 (Date received local registrar) (b) Dr. E. M. Lucke (Registrar's signature) 199

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25 year 1947 hour 11 minute 35 P. M.
21. I hereby certify that I attended the deceased from July 1, 1947 to Oct. 25, 1947 that I last saw him alive on Oct. 25, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	2 Day
Due to Senility	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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 0
23. Signature H B Norton (M. D. or other)
Address Hannibal Mo Date signed Oct. 27/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 John L. Ward Registered Apprentice No. 35 working under my personal supervision.

Signed W. Crawford Smith

Licensed Embalmer No. 3814

P. O. Address Hannibal Missouri

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.