

FILED AUG 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28555

BIRTH NO. #100084 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6914

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
b. CITY OR TOWN St. Louis, Mo.		a. STATE Mo	
c. LENGTH OF STAY (in this place) 1 1/2		b. COUNTY 4th	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		c. CITY OR TOWN LEMAY	
		d. STREET ADDRESS RT # 8 Box 1590	

3. NAME OF DECEASED (Type or Print)	a. (First) PETER	b. (Middle) H.	b. (Last) SLINKARD	4. DATE OF DEATH (Month) (Day) (Year) August 6th, 1949
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 28-1888	9. AGE (In years last birthday) 61	10. UNDER 1 YEAR Months Days	11. UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE APION	10b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL	11. BIRTHPLACE (State or foreign country) Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME PETER J. SLINKARD	13b. MOTHER'S MAIDEN NAME MARY N. MORTON	14. NAME OF HUSBAND OR WIFE IRENE SLINKARD
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME IRENE SLINKARD	ADDRESS RT. 8 Box 1590 LEMAY MO
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphemia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterio sclerotic heart disease.			

18a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 MO
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? M 2 X
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22. I hereby certify that I attended the deceased from 7/30/49, 19, to 8/6/49, 19, that I last saw the deceased alive on 7/30/49, 19, and that death occurred at 12:45 pm, from the causes and on the date stated above.

23a. SIGNATURE Joseph J. Mueller J. M. D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 8/8/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE AUG-9-49	24c. NAME OF CEMETERY OR CREMATORY PARK LAWN	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. AUG 9 1949	REGISTRAR'S SIGNATURE J. B. Hunter	25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schmitt	ADDRESS 3125 LAFAYETTE
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

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.