

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31220

State File No. ....

FILED OCT 9 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 4457 Registrar's No. 48

0930

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

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Town Collins</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Osceola</u>	
c. LENGTH OF STAY (in this place) <u>2</u> years		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>William</u>	b. (Middle) <u>Vernon</u>	c. (Last) <u>Slagle</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>9-2-1951</u>
-------------------------------------	------------------------------	------------------------------	----------------------------	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-28-1880</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months   Days	IF UNDER 24 HRS. Hours   Min.
-----------------------	----------------------------------	--	--------------------------------------	---	----------------------------------	----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	-----------------------------------	--	---

13a. FATHER'S NAME <u>William Slagle</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>Ada Slagle</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Ada Slagle-Collins</u>	ADDRESS
---	-------------------------	--	---------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>chronic nephritis</u>		
	ANTECEDENT CAUSES Morbid 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>592x</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---	---

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)
--	--	---

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?
---	--	----------------------------

22. I hereby certify that I attended the deceased from 6-15, 1950, to 9-2, 1951, that I last saw the deceased alive on 9-2, 1951, and that death occurred at 10 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. E. D. Brown D.O.</u>	23b. ADDRESS <u>Collins Mo.</u>	23c. DATE SIGNED <u>9-5-51</u>
---	------------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-6-1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Mound</u>	24d. LOCATION (City, town, or county) (State) <u>Osceola Mo.</u>
--	------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>9-5-51</u>	REGISTRAR'S SIGNATURE <u>Ruth Seewers</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. ...</u>	ADDRESS <u>Osceola Mo</u>
---	--	---	------------------------------

RECEIVED

10-8-51

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed 10-8-51

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 J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola 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.