

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Scott</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Chaffee</i> <i>1001</i>	
c. LENGTH OF STAY (in this place) <i>2 hours</i>		d. STREET ADDRESS (If rural, give location) <i>342 E. Parker</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Frisco Employees Hospital</i>			

3. NAME OF DECEASED (Type or Print) <i>Clarence Oda Slaughter</i>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <i>March 21, 1953</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Feb 11, 1893</i>	9. AGE (In years last birthday) <i>60</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>10</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>P.R. Engineer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	11. BIRTHPLACE (State or foreign country) <i>Weekly Co., Penn.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Wm. Taylor Slaughter</i>	13b. MOTHER'S MAIDEN NAME <i>Naomi Ellis Slaughter</i>	14. NAME OF HUSBAND OR WIFE <i>Nell Schmidt</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <i>Mary Jean Ellison</i> daughter <i>Chaffee, Mo</i>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Coronary artery occlusion</i>		
	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. <i>Coronary thrombosis in this Hospital 1951 infection</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>3-21-53 3 PM</i>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>4201</i>
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22. I hereby certify that I attended the deceased from *1 PM 3-21-1953* to *3 PM 3-21-1953*, that I last saw the deceased alive on *3-21-1953*, and that death occurred at *3 P m.*, from the causes and on the date stated above.

23a. SIGNATURE <i>Norman E. Miller M.D.</i>	(Degree or title)	23b. ADDRESS <i>4960 Laclede Ave</i>	23c. DATE SIGNED <i>3-21-53</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	24b. DATE <i>3-22-53</i>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <i>Chaffee Mo.</i>
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DATE REC'D BY LOCAL REG. <i>MAR 24 1953</i>	REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Bispinghoff</i>	ADDRESS <i>Chaffee Mo.</i>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 20 1954

MS JUL 8 1953

JUL 1 1953

PER 8 1953

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 *V E Morris*

Licensed Embalmer No. *3360*

P. O. Address *St Louis 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.