

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 11 1954

State File No. _____
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. 52 PRIMARY REG. DIST. NO. 6296

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau, County</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Kinder surp</u>		c. LENGTH OF STAY (in this place) <u>3 Years</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		0/60
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Gravel Hill, Mo.</u>			d. STREET ADDRESS (If rural, give location) <u>Gravel Hill, Mo.</u>		

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Tobitha</u>	b. (Middle) <u>Jane</u>	c. (Last) <u>Slinkard</u>	(Month) <u>4</u>	(Day) <u>27</u>	(Year) <u>54</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/2/1874</u>		9. AGE (in years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>3</u>	IF UNDER 1 YEAR Days <u>25</u>	IF UNDER 1 YEAR Hours _____	IF UNDER 1 YEAR Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife,</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work,</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
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13a. FATHER'S NAME <u>John Welker</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Austin,</u>		14. NAME OF HUSBAND OR WIFE <u>Joe Slinkard</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Joe Slinkard, Burfordsville, Mo.</u>			ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Asthma</u>		DUE TO (b) <u>Dont know</u>		<u>Don't know</u>	
		ANTECEDENT CAUSES		DUE TO (c) _____			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>					

19a. 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) _____	
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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? _____	
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22. I hereby certify that I attended the deceased from April 1, 1954, to April 27, 1954 that I last saw the deceased alive on April 26, 1954, and that death occurred at 12:11 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>D.R. Debernard, M.D.</u>		23b. ADDRESS <u>Jackson, Mo.</u>		23c. DATE SIGNED <u>4-30-54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4/28/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>County Line,</u>		24d. LOCATION (City, town, or county) (State) <u>Gravel Hill, Mo.</u>	
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DATE REC'D BY LOCAL _____	REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>43</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bob Shethy, Lutesville, Mo.</u>			ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0160

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.....

Was Not Embalmed

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.