

FILED OCT 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33136

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1085

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph | | c. LENGTH OF STAY (In this place) 20 Yrs | c. CITY OR TOWN St. Joseph |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 807 South 15th St. | | f. STREET ADDRESS (If rural, give location) 807 South 15th St. | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) Sophia b. (Middle) Mary c. (Last) Sladeck | | | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 8, 1954 | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | |
| 8. DATE OF BIRTH Aug. 2, 1875 | | 9. AGE (In years last birthday) 79 | | 10. IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and State or Foreign Country) Texas | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME Conrad Sladeck | | 13b. MOTHER'S MAIDEN NAME Anna Dubowsky | |
| 14. NAME OF HUSBAND OR WIFE None | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT'S SIGNATURE OR NAME Leo J. Schott Sr. | | 18. ADDRESS 807 So. 15th City | | 19. MEDICAL CERTIFICATION | |

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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, asthenia, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Mitral Stenosis</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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 <i>410 X</i> | | 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) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) | | 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 <i>8/6</i> , 19 <i>54</i> , to <i>10/7</i> , 19 <i>54</i> , that I last saw the deceased alive on <i>10/7</i> , 19 <i>54</i> , and that death occurred at <i>11:30 pm.</i> , from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) <i>Frank Vandegard M.D.</i> | | 23b. ADDRESS <i>620 Francis St. City</i> | | 23c. DATE SIGNED <i>10/11/54</i> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24b. DATE <i>Oct. 11, 1954</i> | | 24c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i> | |
| 24d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Norman W. ...</i> | | ADDRESS <i>St. Joseph, Mo.</i> | |

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| DATE REC'D BY LOCAL REG. <i>Oct 14, 1954</i> | | REGISTRAR'S SIGNATURE <i>Kathleen M. Allison</i> | | 485 | |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed.....
Robert L. Gagliardi

Licensed Embalmer No. 3308

P. O. Address St. Joseph.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.