

FILED MAY 23 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15300

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 139 PRIMARY REG. DIST. NO. 5539 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY <u>Holt</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fortescue MINTON TWP.</u>		c. LENGTH OF STAY (In this place) <u>1 yrs.</u>	c. CITY OR TOWN <u>Fortescue</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>0440</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>WESLEY</u> b. (Middle) <u>ALEXANDER</u> c. (Last) <u>SLONIKER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 9, 1955</u>
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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>Mar. 17, 1904</u>	9. AGE (In years last birthday) <u>51</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Holt County, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>A. W. Sloniker</u>	13b. MOTHER'S MAIDEN NAME <u>Martha E. Ryholt</u>	14. NAME OF HUSBAND OR WIFE <u>Helen W. Sloniker</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>497-14-4539</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Martha Uphouse, Fortescue, Mo.</u>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebro-Vascular Accident</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (c) stating the underlying cause last. DUE TO (b) <u>Cerebral Occlusion</u> DUE TO (c) <u>Cerebral Thrombosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertensive Heart Disease</u>		<u>unknown</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331 X</u>	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) m.	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 July 1, 1954, to 5-9, 1955, that I last saw the deceased alive on 5-8, 1955, and that death occurred at 2:01 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>James J. Sweeney, M.D.</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Cresta, Missouri</u>	23c. DATE SIGNED <u>5/17/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/11/1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Mound City, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>5/17/1955</u>	REGISTRAR'S SIGNATURE <u>James H. Crawford 469</u>	25. FEDERAL DIRECTOR'S SIGNATURE <u>James H. Crawford, Mound City, Mo.</u>	ADDRESS
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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 *James H Crawford*

Licensed Embalmer No. *479*

P. O. Address *Providence City*

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.