

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 27 1955

State File No. **21004**
Registrar's No. **135**

BIRTH NO. _____ REG. DIST. NO. **10** PRIMARY REG. DIST. NO. **5035**

1. PLACE OF DEATH a. COUNTY Audrain		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Audrain	
b. CITY OR TOWN Rural Saling		c. CITY OR TOWN Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saling Township		e. STREET ADDRESS (If rural, give location) Saling Twshp	

3. NAME OF DECEASED (Type or Print) a. (First) Allie b. (Middle) Slavens c. (Last) Slavens			4. DATE OF DEATH (Month) (Day) (Year) July 16th 1955		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 6th 1901	9. AGE (In years last birthday) 53	10. MONTHS 11	11. DAYS 10	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and State or Foreign Country) Mo		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John Slavens		13b. MOTHER'S MAIDEN NAME Nannie Holcomb		14. NAME OF HUSBAND OR WIFE Velma	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME Mrs A. Slavens, RFD Clark, Mo	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Circulatory failure		INTERVAL BETWEEN ONSET AND DEATH 5 Min.	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Mediastinal Metastatic Lymphadenopathy		Not Known	
		DUE TO (c) Bronchiogenic Carcinoma		Not Known	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 162X			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) (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 **9-1**, 19**53**, to **7-16**, 19**55**, that I last saw the deceased alive on **7-16**, 19**55**, and that death occurred at **10:20 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Henry J. Stewart D.D. Surgeon, Mo		23b. ADDRESS Sturgeon, Mo		23c. DATE SIGNED 7-18-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-18-1955		24c. NAME OF CEMETERY OR CREMATORY Oakland	
				24d. LOCATION (City, town, or county) (State) Moberly, Mo	

DATE REC'D BY LOCAL REG. July 18-1955		REGISTRAR'S SIGNATURE Blanche Neely		25. FUNERAL DIRECTOR'S SIGNATURE Mahon and Son	
				ADDRESS Moberly, Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

VS OCT 7 1900

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 *Frank D. DeWitt*.....

Licensed Embalmer No. *302*

P. O. Address *M. Oberly*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.