

FILED DEC 19 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42574**

| | | | | | | | |
|--|-------------------------------|---|--|---|---|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 311 | | PRIMARY REG. DIST. NO. 6054 | | Registrar's No. 41 | |
| 1. PLACE OF DEATH a. COUNTY St. Clair | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) - a. STATE Missouri b. COUNTY St. Clair | | | |
| b. CITY OR TOWN Rural- Osceola | | c. LENGTH OF STAY (in this place) _____ | | c. CITY OR TOWN Rural- Osceola | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION East Osage Township | | | | e. STREET ADDRESS (If rural, give location) East Osage Township 09230 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Samuel | | | b. (Middle) L. | | c. (Last) Slagle | | 4. DATE OF DEATH (Month) (Day) (Year) Dec; 9, 1956 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Oct; 11, 1870 | | 9. AGE (In years last birthday) 86 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 2 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) Brown County Illinois | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME David N. Slagle | | | 13b. MOTHER'S MAIDEN NAME Mary E. Veach | | 14. NAME OF HUSBAND OR WIFE Deceased | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Art Masten, Osceola Missouri | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | | | INTERVAL BETWEEN ONSET AND DEATH 1 mo. | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis | | | | 10 yrs. | |
| | | DUE TO (c) Hypertension | | | | 15 yrs. | |
| | | 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 none Performed | | | | 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) 331x | | | |
| 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? _____ | | | |
| 22. I hereby certify that I attended the deceased from 10/11, 1946 , to 12/9, 1956 , that I last saw the deceased alive on 12/7, 1956 , and that death occurred at 8:00 P.M. from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) M. D. Bjerke, D.O. | | | | 23b. ADDRESS Rockville Missouri | | 23c. DATE SIGNED 12-12-56 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 12/12/56 | 24c. NAME OF CEMETERY OR CREMATORY Pleasant Mound | | 24d. LOCATION (City, town, or county) (State) Osceola Missouri | | |
| DATE REC'D BY LOCAL REG. 12-17-1956 | | REGISTRAR'S SIGNATURE Elvo Abney | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.B. ... Osceola Mo | | | |

Licensed Embalmer's Statement on Reverse Side)

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

285
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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 *Paul T. [unclear]*.....

Licensed Embalmer No. *399*.....

P. O. Address *Osceola*.....

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.