

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3639

STATE FILE NUMBER

FILED MAR 13 1957

Registration District No. 10 Primary Registration District No. 5034 Registrar's No. 53

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Prairie</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Laddonia, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0040
c. FULL NAME OF (If in hospital, give location) HOSPITAL OR INSTITUTION <u>4 Mils. West of Laddonia, Mo.</u> Length of stay in 1b		d. STREET ADDRESS <u>4 Mils. West of Laddonia, Missouri</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence Jefferson Slavens</u> First Middle Last			4. DATE OF DEATH <u>3 6 1957</u> Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-1885</u>
9. AGE (In years last birthday) <u>71</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Warming</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country) <u>Audrain County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas J. Slavens</u>		14. MOTHER'S MAIDEN NAME <u>Elberry</u>	
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>495-40-9532</u>	17. INFORMANT <u>Mrs. Della Slavens Laddonia, Mo.</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cardio-vascular degeneration</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u> <u>2 yr.</u> <u>10 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>3-1-55</u> to <u>3-6-57</u> and last saw ^{her} him alive on <u>3-6-57</u> Death occurred at <u>4:10</u> P.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E. W. Lindsey D.O.</u>		22b. ADDRESS <u>Laddonia, Missouri</u>	22c. DATE SIGNED <u>3-7-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-8-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laddonia Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Laddonia, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Willard Dierhoff, Laddonia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Mar. 8, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1951 OCT NOV

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 *Clyde Hill*

Licensed Embalmer No. *38*

P. O. Address *Perry*

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.