

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16276

STATE FILE NUMBER

FILED MAY 27 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 556

|  |                        |  |  |
|--|------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Buchanan                            |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                        | c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp. Length of stay in lb most of life   |                        | d. STREET ADDRESS 509 N. 9th St. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>          |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last ETHER E. SLATER  |                        |  | 4. DATE OF DEATH Month Day Year May 15, 1957                       |
| 5. SEX male  | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 6, 1876                                  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer   |                        | 9b. KIND OF BUSINESS OR INDUSTRY Railroad Co.  | 9c. BIRTHPLACE (City and state or country) Indiana                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer  |                        | 10b. KIND OF BUSINESS OR INDUSTRY Railroad Co.   | 10c. BIRTHPLACE (City and state or country) Indiana                |
| 11. BIRTHPLACE (City and state or country) Indiana   |                        | 12. CITIZEN OF WHAT COUNTRY? USA   |  |
| 13. FATHER'S NAME Warren D. Slater   |                        | 14. MOTHER'S MAIDEN NAME Levine R. Lengel  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.#1   |                        | 16. SOCIAL SECURITY NO. unknown  |  |
| 17. INFORMANT Mrs. Olive Huffman, R.R. #1, So. Whitley, Ind.   |                        | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary occlusion<br>DUE TO (b) Coronary sclerosis<br>DUE TO (c) arteriosclerosis general<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arrhythmial asthma. Diabetes Mellitus |                        |  | INTERVAL BETWEEN ONSET AND DEATH 24 hours                          |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                        | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                        | 20b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.  |                        | 20d. CITY, TOWN, OR LOCATION COUNTY STATE  |  |
| 20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                        | 20f. CITY, TOWN, OR LOCATION COUNTY STATE  |  |
| 21. I attended the deceased from May 15, 1957 to May 15, 1957 and last saw him alive on May 14, 1957. Death occurred at 2:00a. m on the date stated above; and to the best of my knowledge, from the causes stated.  |                        |  |  |
| 22a. SIGNATURE (Degree or title) L. E. Lenon M.D.  |                        | 22b. ADDRESS St. Joseph Mo   |  |
| 22c. DATE SIGNED 5-17-57   |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   | 23b. DATE 5/18/1957    | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery   | 23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri |
| 24. FUNERAL DIRECTOR Heaton-Dowman Funeral Home, St. Joseph, Mo.   |                        | 25. DATE RECD. BY LOCAL REG. May 23, 1957  |  |
| 26. REGISTRAR'S SIGNATURE Eather M. Allison  |                        |  |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 certifies to a death due to natural causes.  
MEDICAL CERTIFICATION

MAY 28 1957  
MAY 29 1957

OCT 23 1957

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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..... *James B. Hawkins*  
Licensed Embalmer No. 45

P. O. Address *319 So. 10th St.*

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.