

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17357

FILED MAY 21 1957

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2135

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>9117 SUMMIT STREET</u>	
Length of stay in lb <u>35 yrs.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE I SLENKER</u>			4. DATE OF DEATH Month Day Year <u>MAY 3 1957</u>
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>JAN-29, 1908</u>
9. AGE (In years last birthday) <u>49 49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASSISTANT VICE PRESIDENT</u>	11. BIRTHPLACE (City and state or country) <u>HARRISONVILLE, MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CLIFFORD SLENKER</u>	
13b. MOTHER'S MAIDEN NAME <u>NANCY RAGON</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. MARGARET SLENKER</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>496-16-8281</u>	
17. INFORMANT <u>MRS. MARGARET SLENKER</u>		Address <u>9117 SUMMIT STREET KANSAS CITY, MO.</u>	
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>metastatic carcinoma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma Lung Primary</u> DUE TO (c) <u>J</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>162x</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <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>1955</u> to <u>May 3rd 1957</u> and last saw her alive on <u>May 3 1957</u> Death occurred at <u>8:10 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wm. R. Jackson MD</u>		22b. ADDRESS <u>1107 Bayard Bldg</u>	
22c. DATE SIGNED <u>5/4/57</u>		22d. (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAY 6 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM.</u>		23d. LOCATION (City, town, or county) <u>KANSAS CITY MISSOURI</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMERS SONS</u>		ADDRESS <u>1331 BASH CREEK K.C., MO.</u>	
25. DATE RECD. BY LOCAL REG. <u>5-6-57</u>		26. REGISTRAR'S SIGNATURE <u>neva minshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

Wm. R. Jackson



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 *Ederett L. Smith*

Licensed Embalmer No. *5001*

P. O. Address *K. C. Mo*

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.