

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31091**

FILED OCT 14 1957

BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3009** Registrar's No. **458**

1. PLACE OF DEATH a. COUNTY Cane Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cane Gir	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jackson		c. LENGTH OF STAY (In this place) OR TOWN 81 Yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 525 Hope St.		d. STREET ADDRESS (If rural, give location) 525 Hope St.	

3. NAME OF DECEASED (Type or Print) a. (First) Cora	b. (Middle)	c. (Last) Slack	4. DATE OF DEATH (Month) (Day) (Year) Oct. 1 1957
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Dec. 5, 1875	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME J. Frank Slack	13b. MOTHER'S MAIDEN NAME Malissa Hicks	14. NAME OF HUSBAND OR WIFE Not Married
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Miss Winnie Slack	ADDRESS Jackson, Mo.
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH Four Days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
	DUE TO (c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4222	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Oct. 1 - 1957**, **she was dead a few minutes after I received the report** and that death occurred at **11 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE W. J. Seabury, M.D. (Degree or title)	23b. ADDRESS Jackson Mo	23c. DATE SIGNED 10-4-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 4 1957	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) Jackson Mo.
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DATE REC'D BY LOCAL REG. 10-9-57	REGISTRAR'S SIGNATURE W. C. Summers	25. FUNERAL DIRECTOR'S SIGNATURE H. C. Crawford	ADDRESS Jackson, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

446

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 _____
working under my personal supervision.

Student Embalmer No.

Signed *Gene O. Conroy*

Signed.....
Student Embalmer

Licensed Embalmer No. 4357

P. O. Address Jackson, Me.

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 this body is not embalmed, fact should be so stated above.