

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34151
STATE FILE NUMBER
8477
Registrar's No.

FILED SEP 23 1957

Registration District No. 318 Primary Registration District 1003

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 440 Mo. Pacific Hospital			Length of stay in 1b 12 Years	d. STREET ADDRESS 1402 Morrison Ave		(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 Greer NMN Slinkard				4. DATE OF DEATH Month Day Year Sept. 10, 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 27, 1895		9. AGE (In years last birthday) 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crossing Watchman		10b. KIND OF BUSINESS OR INDUSTRY Terminal R.R.		11. BIRTHPLACE (City and state or country) Burfordville, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Slinkard				14. MOTHER'S MAIDEN NAME Alice Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.#1		16. SOCIAL SECURITY NO. 493-01-9089		17. INFORMANT Address Mrs Bernice Slinkard 1402 Morrison Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) <i>Coronary Sclerosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201							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 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 _____, to _____ and last saw her/him alive on _____ Death occurred at <i>240A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Patrick C. Taylor Coroner</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>9.10.57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal (Auto)</i>		23b. DATE <i>9/10/57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Russell Heights Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Jackson, Missouri</i>		
24. FUNERAL DIRECTOR <i>Jackson, Mo</i> <i>Cracraft - Miller Funeral Home</i>				25. DATE RECD. BY LOCAL REG. <i>SEP 10 57</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i> <i>MSB</i>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

SEP 25 1957

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 *Jos. E McEulloch*

Licensed Embalmer No. *24*

P. O. Address *6175 D*

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.