

pt. Health,  
c., & Welfare  
S. Public  
alth Service

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

17373  
STATE FILE NUMBER  
6119  
Registrar's No.

FILED JAN 17 1958

Registration District No. 149 Primary Registration District No. 1007

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jacks on</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jacks on</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. Hospital</b>		Length of stay in 1b <b>1 yr</b>	d. STREET ADDRESS <b>3007 Askew</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LEE</b> Middle <b>W.</b> Last <b>SLUSHER</b>			4. DATE OF DEATH Month <b>12th</b> Day <b>20th</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-3-21</b>	9. AGE (In years last birthday) <b>36 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garment</b>	11. BIRTHPLACE (City and state or country) <b>McAlester, Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Fred Slusher</b>		13b. MOTHER'S MAIDEN NAME <b>Helen Colbert</b>		14. NAME OF HUSBAND OR WIFE <b>Emma L. Slusher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>443 14 7432</b>		17. INFORMANT Address <b>V.A. Hospital Records, K.C., Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b>					INTERVAL BETWEEN ONSET AND DEATH  <b>491X</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Hemorrhagic necrotizing bronchopneumonia</b>					
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 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 _____ a.m. _____ p.m. Month, Day, Year _____					
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 <b>December 14, 1957</b> to <b>December 20, 1957</b> and last saw him alive on _____ Death occurred at <b>12:20</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>A. J. Williams, M.D.</b>			22b. ADDRESS <b>V.A. Hospital, K.C., Mo</b>		22c. DATE SIGNED <b>12-20-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Dec. 12, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Tulsa, Oklahoma</b>
24. FUNERAL DIRECTOR ADDRESS <b>Mrs. Meek's Funeral Home, K.C., Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>12-24-57</b>	26. REGISTRAR'S SIGNATURE <b>Reva Minshall</b>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

27

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 *Millard B. Faskin*

Licensed Embalmer No. *5013* P. O. Address *H. C. 1710*

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.