

Health, Welfare, Public Service

FILED MAR 17 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008830
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 113

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Columbia</u> Inside Limits <u>1605</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>204 N. 1st St</u>		Length of stay in lb <u>24 hr.</u>	d. STREET ADDRESS (If outside, give location) <u>204 N. 1st St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS J. SLATTERY</u>			4. DATE OF DEATH Month Day Year <u>March 7 - 1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16 - 1875</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kitchen helper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Ruben Fields</u>		13b. MOTHER'S MAIDEN NAME <u>Queenie Janner</u>		14. NAME OF HUSBAND OR WIFE <u>Christena Slater</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>715-03-5489</u>	17. INFORMANT Address <u>Christena Slater, Columbia, 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>Myocardial Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs - 1 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypo Static Pneumonia</u>	
	DUE TO (c) <u>Prostatic Carcinoma + Metastases</u>	
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 type="checkbox"/> NO <input checked="" 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.) <u>2</u>		
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 <u>Columbia</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
--	--	---	----------------------	---------------------

21. I attended the deceased from Feb 16, 1955 to March 7, 1958 and last saw him alive on March 7, 1958
Death occurred at 7 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Roland H. Wiggins, M.D.</u>	22b. ADDRESS <u>201 North Third St. Columbia, Mo.</u>	22c. DATE SIGNED <u>3/11/58</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>3/12/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loggrounville</u>	23d. LOCATION (City, town, or county) (State) <u>Loggrounville, Mo.</u>
24. FUNERAL DIRECTOR <u>Mrs. Stuart Parker, Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>March 12, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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 *Gayle H. Green*

Licensed Embalmer No. *4220*

P. O. Address *Marshall 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.