

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012315

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2525

300

-57

|  |                           |   |  |  |   |
|--|---------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Missouri<br>b. COUNTY |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>St. Louis   |                           | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN<br>St. Louis   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                 |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br>01 4933 Pernod Ave.  |                           | Length of stay in 1b  | d. STREET ADDRESS<br>21470 4933 Pernod Ave.  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>William E Sledd  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>Feb. 28 1958   |  |   |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Aug. 11, 1891  |  | 9. AGE (In years last birthday)<br>66<br>IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Chauffeur   |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br>St. Louis, Mo. |   |
| 13a. FATHER'S NAME<br>William E. Sledd   |                           | 13b. MOTHER'S MAIDEN NAME<br>Dont Know  |  | 14. NAME OF HUSBAND OR WIFE<br>Hazel Burgess Sledd           |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>Yes Navy W.W.#1   |                           | 16. SOCIAL SECURITY NO.<br>488-10-2529  |  | 17. INFORMANT<br>Address<br>Hazel Sledd 4933 Pernod Ave.     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b)<br>DUE TO (c) arteriosclerotic heart disease<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>420.0 |                           |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>at once   |
| 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<br>Hour Month, Day, Year<br>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 Feb 1957 to Feb 1958 and last saw her alive on Feb 26, 1958<br>Death occurred at 11:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |  |  |   |
| 22a. SIGNATURE (Degree or title)<br>Leroy P. Ortmeier M.D.   |                           |   | 22b. ADDRESS<br>1515 Lafayette, St. Louis, Mo  |  | 22c. DATE SIGNED<br>MAR 3 '58   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 23b. DATE<br>3-4-1958   | 23c. NAME OF CEMETERY OR CREMATORY<br>Kalvary Cemetery   |  | 23d. LOCATION (City, town, or county) (State)<br>St. Louis, Mo.   |
| 24. FUNERAL DIRECTOR<br>Cullinane Bros. 3320 N. Kingshighway   |                           |   | 25. DATE RECD. BY LOCAL REG.<br>MAR-3 '58  | 26. REGISTRAR'S SIGNATURE<br>Carl Smith M.D.<br>MRS          |   |

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 *E. J. Remelius* .....

Licensed Embalmer No. *4283* .....

P. O. Address *St. Louis, 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.