

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018935

STATE FILE NUMBER

FILED JUN 2 1958 Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 320

1. PLACE OF DEATH a. COUNTY <b>LINN</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>LINN</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MARCELINE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>MARCELINE</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>ST. FRANCIS</b>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>E. GRACIA</b>			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES WILLIAM SLAUGHTER</b>				4. DATE OF DEATH Month Day Year <b>MAY 26 1958</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV 25 1896 67</b>		9. AGE (In years last birthday) <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (City and state or country) <b>MARCELINE MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JAMES HENRY SLAUGHTER</b>				14. MOTHER'S MAIDEN NAME <b>MARY CUPP</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>FRED SLAUGHTER</b>		Address <b>MARCELINE</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>Cerebrovascular Accident</b>								INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Diabetic atherosclerotic cardiovascular disease</b>							
		DUE TO (c) <b>4201</b>							
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus + Hypocholic Impaction (etc.)</b>								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.)						
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 <sup>her</sup> him alive on <b>5-27-58</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Marceline Miller</i> (Degree or title)				22b. ADDRESS <b>Marceline Miller</b>			22c. DATE SIGNED <b>5-27-58</b>		
23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5-28-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>			23d. LOCATION (City, town, or county) <b>MARCELINE MO.</b>		(State)	
24. FUNERAL DIRECTOR <b>MILLER-Tillotson</b>				ADDRESS <b>MARCELINE</b>		25. DATE RECD. BY LOCAL REG. <b>5-27-58</b>		26. REGISTRAR'S SIGNATURE <i>Brookie Owen</i>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

000-56

Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ex  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Silbren K Tella*

Licensed Embalmer No... *4*

P. O. Address *Mare*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.