

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023927
STATE FILE NUMBER

FILED JUL 11 1958 Registration District No. 317 Primary Registration District No. 531 Registrar's No. 1680

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN University City		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7437 Stratford Ave.		d. STREET ADDRESS (If outside, give location) 7437 Stratford Avenue	

3. NAME OF DECEASED (Type or print) First GORDON Middle F. G. Last SLOAS			4. DATE OF DEATH Month June Day 23rd Year 1958		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1898	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prod. Worker - Bachman	10b. KIND OF BUSINESS OR INDUSTRY Machine Company	11. BIRTHPLACE (City and state or country) Unknown	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Elliot Sloas	13b. MOTHER'S MAIDEN NAME Henrietta Willis	14. NAME OF HUSBAND OR WIFE Agnes Lula Sloas
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. 491-26-9165	17. INFORMANT Address Mrs. James N. Ozee 7437 Stratford Avenue
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus		INTERVAL BETWEEN ONSET AND DEATH 150X
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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.)
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20c. TIME OF INJURY Hour _____ .Month, Day, Year 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 _____
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21. I attended the deceased from Death occurred at 7:00 A. on 6/1/58 to 6/23/58 and last saw him alive on 6/23/58 m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) Thomas W. Parker M.D.	22b. ADDRESS 4660 Maryland Avenue	22c. DATE SIGNED 6/23/1958
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/23/1958	23c. NAME OF CEMETERY OR CREMATORY Mounds Cemetery	23d. LOCATION (City, town, or county) (State) Marston, Missouri
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24. FUNERAL DIRECTOR ADDRESS C. R. Lupton & Sons 7233 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. 6-23-58	26. REGISTRAR'S SIGNATURE Herbert R. Donke M.D.
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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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*
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.