

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025919  
STATE FILE NUMBER

FILED JUL 22 1958 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 295

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Independence 7005</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>Independence Hospital 13 yrs</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>514 South Noland</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Elizabeth</b> Last <b>Slayton</b>			4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>1958</b>			
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5. SEX <b>Female</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. 5, 1878</b>	9. AGE (In years last birthday) <b>79</b>	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	11. BIRTHPLACE (City and state or country) <b>Mount Hope, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Jack Marks</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Bakerstoft</b>	14. NAME OF HUSBAND OR WIFE <b>Otto Earl Slayton</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. James Fountain</b> Address <b>514 So. Noland</b>
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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) <b>Carcinoma of Colon</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Not Known</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <b>1538</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 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.)
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20c. TIME OF INJURY Hour _____ 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 <b>Independence</b>	COUNTY <b>Missouri</b>	STATE
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21. I attended the deceased from <b>6-26-58</b> to <b>7-13-58</b> and last saw her alive on <b>7-13-58</b> Death occurred at <b>7/13/58 4:35 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Drs. Grabske &amp; Link</b>	22b. ADDRESS <b>10901 Winner, Indep., Mo.</b>	22c. DATE SIGNED <b>7-14-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 15, '58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mound Grove</b>	23d. LOCATION (City, town, or county) (State) <b>Independence Missouri</b>
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24. FUNERAL DIRECTOR <b>Roland R. Speaks</b> ADDRESS <b>Indep. Mo</b>	25. DATE RECD. BY LOCAL REG. <b>7-15-58</b>	26. REGISTRAR'S SIGNATURE <i>James S. Slayton</i>
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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 .....  
*Rollie Kessel*

Licensed Embalmer No. *4690* .....  
P. O. Address *Indep. 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.