

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035584

STATE FILE NUMBER

1171

FILED NOV 10 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

S. 300
1-57
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.		Length of stay in 1b 56 years		0117 0 STREET ADDRESS 1031 Faraon		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First FRANCIS Middle WILLIAM Last SLADE				4. DATE OF DEATH Month Oct. Day 31 Year 1958				
5. SEX male <input type="radio"/>	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1866		9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		10b. KIND OF BUSINESS OR INDUSTRY Wyeth Wholesale Co.		11. BIRTHPLACE (City and state or country) Charlestown, Indiana		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME William Slade			13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Deborah Slade			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Francis Slade, 1031 Faraon, St. Joseph, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 5 da		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Broncho pneumonia		DUE TO (c) Arteriosclerotic cardio vascular disease		aggravated 5 da ?		
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"/> 2		
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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>								
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 10-20-58 to 10-31-58 and last saw him alive on 10-20-58 Death occurred at 6:30p. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Wm B Root M D (Degree or title)			22b. ADDRESS 316 North St Joseph Mo		22c. DATE SIGNED 11-1-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 11/3/1958	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) St. Joseph Mo.		(State)	
24. FUNERAL DIRECTOR Horton - Bowman			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Nov. 3, 1958		26. REGISTRAR'S SIGNATURE Mrs. Clark Hodell	

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 *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *St. Joseph, 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.