

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021845

FILED JUL 9 1959

STATE FILE NUMBER

Registration District No. 150

Primary Registration District No. 700 4239

Registrar's No. 152

300
1-57
0

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 JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY JACKSON				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LEE'S Summit		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN LEE'S Summit		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 608 Jefferson Summit 1 YEAR			Length of stay in lb		d. STREET ADDRESS (If outside, give location) 608 JEFFERSON		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Theodore Sloan				4. DATE OF DEATH Month Day Year June 25 1959				
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 July 2, 1889		9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 11 Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Clay County, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME DANIEL T. SLOAN			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE EDNA MAE SLOAN		
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. 500-12-1710		17. INFORMANT Address Mrs. GRATTON PRICE HARRISONVILLE, 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) <u>RESPIRATORY FAILURE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>PULMONARY EDEMA</u>		DUE TO (c) <u>BRONCHOPNEUMONIA</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebrovascular Accident.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>491X</u>					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		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 <u>June 9, 1959</u> to <u>June 25, 1959</u> and last saw him alive on <u>June 25, 1959</u> Death occurred at <u>4:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>William J. Rhoads MD</u>				22b. ADDRESS <u>320 S. Douglas Lee's Summit</u>			22c. DATE SIGNED <u>6-25-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>6-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BYLER Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Creighton, Missouri</u>			
24. FUNERAL DIRECTOR <u>Atkinson Dickie Harrisonellato</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>6-27-59</u>		26. REGISTRAR'S SIGNATURE <u>W. B. Langford</u>	

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 *Robert W. [Signature]*

Licensed Embalmer No. *4902*
P. O. Address *Hammond, La.*

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.