

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024149

FILED VS. AUG 10 1959

Registration District No. _____ Primary Registration District No. 3006 Registrar's No. 347

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>COLUMBIA</u>		Length of stay in 1b <u>10 days</u>		c. CITY OR TOWN <u>Portageville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Medical Center</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 6 Box 3</u>		
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>Lee</u> Last <u>Slaughter</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1959</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUC</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-22-03</u>		
9. AGE (last birthday) <u>56</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Miles Wesley Slaughter</u>			13b. MOTHER'S MAIDEN NAME <u>MAYBELL CAPPS</u>			14. NAME OF HUSBAND OR WIFE <u>MAE Slaughter</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Hospital Records Columbia, Mo.</u>		
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>ACUTE MYOCARDIAL INFARCTION</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2-3 DAYS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.		Month, Day, Year						
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 <u>7/27/59</u> to <u>8/5/59</u> and last saw her alive on <u>8/5/59</u> Death occurred at <u>7:37 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>J. J. Sanders</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Univ of Mo. Med Center</u>			22c. DATE SIGNED <u>8/6/59</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>8/10/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Portageville City Cem.</u>		23d. LOCATION (City, town, or county) <u>Portageville, Mo.</u>		
24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u> ADDRESS <u>Columbia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Aug. 7 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Lyman Spunkle

Licensed Embalmer No. *4013*

P. O. Address *Columbia*

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