

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033359

FILED VS OCT 8 1959

282

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 113

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Polk</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Polk</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Pleasant Hope</u>		Length of stay in 1b <u>40 yrs.</u>	c. CITY OR TOWN <u>Pleasant Hope</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Died in the Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Annina</u> Last <u>Slaght</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16 - 1874 - 85</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Howard Harris Allen</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Hobbs</u>	14. NAME OF HUSBAND OR WIFE <u>Martha Slaght</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mo.</u>	17. INFORMANT <u>Mrs. Lois Slaght</u> Address <u>Pleasant Hope 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>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10-20 yrs.</u>
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) <u>Inanition, chronic cholecystitis</u>		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	
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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.)	
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 July '57 to 7/27/59 and last saw her alive on 7/27/59
 Death occurred at 12:01 P.M. on the 7/29/59 and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>SC Wittner, M.D.</u>		22c. ADDRESS <u>800 Med Arts Bldg Springfield, Missouri</u>		22c. DATE SIGNED <u>9/29/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Slaght Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Polk Co. Mo.</u>	

24. FUNERAL DIRECTOR <u>Pitts F. H. Bolivar, Jr.</u>	ADDRESS <u>_____</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 1, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Ralph Gordonpernell</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 Richard J. Petta

Licensed Embalmer No. 4931

P. O. Address Polina

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.