

**U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035896**

FILED VS NOV 2 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 1150

ENDED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in lb <u>38 years</u>	c. CITY OR TOWN <u>Springfield</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>Burge Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2111 Elizabeth</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>OCIE</u> Middle <u>E.</u> Last <u>SLOAN</u>			4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>July 8, 1901</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Laborer (West Shops)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frisco Railway</u>	11. BIRTHPLACE (City and state or country) <u>Polk Co., Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James Sloan</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Yarberry</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Cora Sloan</u>	
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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) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs Cora Sloan, Springfield, Mo.</u>		
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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) <u>Chronic Glomerulonephritis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several years</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)			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 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 _____ s.m. _____ p.m. _____		Month, Day, Year _____			
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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 <u>Springfield, MO.</u>		COUNTY _____	STATE _____
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21. I attended the deceased from <u>3-20-58</u> to <u>10-26-59</u> and last saw him <u>alive</u> on <u>10-26-59</u> Death occurred at <u>10:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
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22a. SIGNATURE (Degree or title) <u>Harold K. Lurie, M.D.</u>		22b. ADDRESS <u>609 Cherry Springfield, MO.</u>		22c. DATE SIGNED <u>10-27-59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-31-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>		
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24. FUNERAL DIRECTOR <u>Jewell E. Windle</u> ADDRESS <u>Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie B. Melton</u>		
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

8961 E AOW SA

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 Bernard F. White

Licensed Embalmer No. 429

P. O. Address Spring

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.