

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005148

FILED VS. MAR 14 1960 38

Registration District No. 3606 Registrar's No. 138

STATE FILE NUMBER

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>Boone</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>4 days.</u>		c. CITY OR TOWN <u>Columbia</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>University Medical Center</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>417 N. Third Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>HARRISON</u> Last <u>SLATER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1960</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</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>4-23-89</u>	9. AGE (last birthday) <u>70</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		11. BIRTHPLACE (City and state or country) <u>Boone County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>		
13a. FATHER'S NAME <u>Smith Slater</u>			13b. MOTHER'S MAIDEN NAME <u>CANNIE BLACKBURN</u>			14. NAME OF HUSBAND OR WIFE <u>Susie Belle Slater</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>4-91-36-7259A</u>		17. INFORMANT <u>Medical Records.</u>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>Generalized peritonitis</u> <u>Ruptured appendix</u> DUE TO (a) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Bronchopneumonia</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			
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>(I did not attend this man)</u> and last saw <u>her</u> alive on <u>7:40 AM 3-4-60</u> Death occurred at <u>7:42 3-4-60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Deedee or title) <u>John Keith Logan M.D.</u>				22b. ADDRESS <u>U. Hospital Columbia Mo</u>			22c. DATE SIGNED <u>3-4-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 8 - 1960</u>	23c. NAME OF CEMETERY, OR CREMATORY <u>Loggins</u>		23d. LOCATION (City, town, or county) (State) <u>Boone County, Mo.</u>					
24. FUNERAL DIRECTOR <u>Mrs. Stuart Puker, Columbia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Mar. 7, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 17 1960

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

George D. Vannoy

Licensed Embalmer No. 4425

P. O. Address Columbia

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.