

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

FILED VS SEP 20 1960 120

-60-034369

INDEXED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 64

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Gentry				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Gentry			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Stanberry		Length of stay in 1b 2 years		c. CITY OR TOWN Stanberry		Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION S.W. Stanberry		Inside Limits Yes ☒ No ☐		d. STREET ADDRESS (If outside, give location) S.W. Stanberry		Reside on Farm Yes ☐ No ☒	
3. NAME OF DECEASED (Type or print) First Ira Middle William Last Slater				4. DATE OF DEATH Month Sept. Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐		8. DATE OF BIRTH 8/27/89	
9. AGE (last birthday) 71		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) farming		10b. KIND OF BUSINESS OR INDUSTRY agriculture		11. BIRTHPLACE (City and state or country) Gentry Co., Missouri		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Mark Slater		13b. MOTHER'S MAIDEN NAME Rosilla Alkire		14. NAME OF HUSBAND OR WIFE Orilla Francis Slater			
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. 493 42 4896		17. INFORMANT Address Mrs. Ira W. Slater Stanberry, 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) Carcinoma of Rectum Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) unknown DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None						INTERVAL BETWEEN ONSET AND DEATH months	
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown							
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) C			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Gentry Co., Missouri		COUNTY _____ STATE _____	
21. I attended the deceased from 6-4-51 to 9-11-60 and last saw him alive on 9-11-60 Death occurred at 819 A. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Clarence L. Carlson M.D. (Degree or title)				22b. ADDRESS Stanberry Mo		22c. DATE SIGNED 9-12-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 13-60		23c. NAME OF CEMETERY OR CREMATORY Berlin		23d. LOCATION (City, town, or county) (State) Gentry Co., Missouri	
24. FUNERAL DIRECTOR Brooks-Cochell Funeral Home, Albany, Mo.				25. DATE RECD. BY LOCAL REG. 9-13-60		26. REGISTRAR'S SIGNATURE Mrs. L. W. Bare	

(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 me, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald E. Cochett

Licensed Embalmer No. 4868

P. O. Address Albany, Mo.

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.