

II. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1960

-60-041682

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 1122 A

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Greene</u>	a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>		admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>	Length of stay in 1b	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>Handley Hospital</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1455 N. Lexington</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			First <u>George</u> Middle <u>William</u> Last <u>Slavens</u>		4. DATE OF DEATH		Month <u>Nov.</u> Day <u>5</u> Year <u>1960</u>
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>1-22-1891</u>		9. AGE (last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Const.</u>		11. BIRTHPLACE (City and state or country) <u>Laclede Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Jedder O. Slavens</u>		13b. MOTHER'S MAIDEN NAME <u>Maryle Brown</u>		14. NAME OF HUSBAND OR WIFE <u>Elma Slavens</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>none</u>		17. INFORMANT <u>Mrs. Elma Slavens, Springfield, Mo.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>14 Mo</u>
IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate</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 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Aug 1959</u> to <u>Nov 1960</u> and last saw her/him alive on <u>4 Nov 60</u> Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Edwin Maxwell M.D.</u>		22b. ADDRESS <u>Springfield Mo</u>		22c. DATE SIGNED <u>11-12-60</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-19-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>		23d. LOCATION (City, town, or county) <u>Springfield, Mo.</u>

24. FUNERAL DIRECTOR <u>Rex Rainey, Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-14-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</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 W. E. Mason

Licensed Embalmer No. 4568

P. O. Address Springfield

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.