

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005234

STATE FILE NUMBER

Registration District No. 144 Primary Registration District No. 4234 Registrar's No. 16

AMENDED

ED VS FEB 24 1961

1. PLACE OF DEATH a. COUNTY Iron		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Iron	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ironton		Length of stay in 1b 6 wks	c. CITY OR TOWN Annapolis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) General Delivery
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last JAMES MONROE SLUSHER			4. DATE OF DEATH Month Day Year Feb. 9 1961		
-----------------------------------------------------------------------------------------	--	--	----------------------------------------------------------	--	--

5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1 1888	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------------	-------------------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Annapolis Missouri	12. CITIZEN OF WHAT COUNTRY USA
--------------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME Monroe Slusher	13b. MOTHER'S MAIDEN NAME Minerva Hale	14. NAME OF HUSBAND OR WIFE Selma Funk Slusher
---------------------------------------------	--------------------------------------------------	----------------------------------------------------------

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.	17. INFORMANT Selma Slusher, Annapolis Mo.	Address
------------------------------------------------------------------------------------------------------------------------	-------------------------	------------------------------------------------------	---------

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 Pancreas		INTERVAL BETWEEN ONSET AND DEATH 7 mos
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	
-----------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

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 <u>11-2-61</u> to <u>2-9-61</u> and last saw ^{her} him alive on <u>2-9-61</u> Death occurred at <u>5.50 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Dee or title) <i>[Signature]</i>	22b. ADDRESS M.D. Strand Mo	22c. DATE SIGNED
-----------------------------------------------------	---------------------------------------	------------------

23a. BURIAL, CREMATION, REBURIAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
--------------------------------------------	-----------	------------------------------------	-----------------------------------------------

24. FUNERAL DIRECTOR White Funeral Home, Ironton Mo.	25. DATE RECD. BY LOCAL REG. 2-12-61	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
----------------------------------------------------------------	------------------------------------------------	-------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

APR 14 1961

VS FEB 27 1961

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 Anell White

Licensed Embalmer No. 3012

P. O. Address Proctor, N.C.

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.