MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-029034

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 199

AMENDED

FILED AUG 28 1961

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY: Henry
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clinton
Length of stay in 1b: 13 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Wetzel Hospital
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: St. Clair
c. CITY OR TOWN: Lowry City
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Jennie Jane Middle: Last: Sloan
4. DATE OF DEATH: Month Aug. Day 21 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2/20/81
9. AGE (last birthday): 80
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): Housekeeping
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St. Charles Iowa
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Samuel T. Johnston
13b. MOTHER'S MAIDEN NAME: Martisha Phipps
14. NAME OF HUSBAND OR WIFE: W.G.Sloan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Carrie Lacey, Lowry City Mo. Address

MEDICAL CERTIFICATION

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
IMMEDIATE CAUSE (a)	Pulmonary Edema	12 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Myocardial Insufficiency	24 hrs
DUE TO (c)	Cerebral Thrombosis	14 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerosis - Senility

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.)
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 COUNTY STATE

21. I attended the deceased from 8-10-61 to 8-21-61 and last saw her alive on 8-21-61
Death occurred at 7:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Clinton L. Gleaspy, D.O. (Degree or title)
22b. ADDRESS: Clinton Missouri
22c. DATE SIGNED: 8/22/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8/24/61
23c. NAME OF CEMETERY OR CREMATORY: Lowry City
23d. LOCATION (City, town, or county) (State): Lowry City Mo

24. FUNERAL DIRECTOR: Goodrich Funeral Home, Osceola Mo; ADDRESS
25. DATE RECD. BY LOCAL REG.: Aug. 23, 1961
26. REGISTRAR'S SIGNATURE: Mildred Bigum

(Licensed Embalmer's Statement on Reverse Side)

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 F B Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola Wis

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.