

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047544

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 391 Primary Registration District No. 4505 Registrar's No. 28

AMENDED

FILED DEC 20 1961			
1. PLACE OF DEATH a. COUNTY STODDARD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BELL CITY	Length of stay in lb MAY 1960	c. CITY OR TOWN CHAFFEE	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SHETLEY NURSING HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 307 HELEN AVE.
3. NAME OF DECEASED (Type or print) First JACOB Middle ALEXANDER Last SLINKARD		4. DATE OF DEATH Month NOV. Day 16 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-21-1877
9. AGE (last birthday) 84	IF UNDER 1 YEAR Months 2 Days 25	IF UNDER 24 HR Hours 25 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER (RET.)		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (City and state or country) BURFORDVILLE, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JAMES E. SLINKARD	13b. MOTHER'S MAIDEN NAME MARY E. ALLEN
14. NAME OF HUSBAND OR WIFE ELLA SLINKARD		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. NONE
17. INFORMANT J.C. SLINKARD		Address CHAFFEE, 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) Chronic Bronchitis			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
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 28 July 58 to 13 Nov 61 and last saw him alive on 13 Nov 61 Death occurred at 16 Nov 61 on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS Chaffee Mo	22c. DATE SIGNED 10 Dec 61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Nov. 18, 1961	23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY	23d. LOCATION (City, town, or county) (State) BURFORDVILLE, MISSOURI
24. FUNERAL DIRECTOR DISPLINGHOFF FUNERAL HOME - CHAFFEE, Mo.		ADDRESS 2214/61	25. DATE RECD. BY LOCAL REG. 2/14/61
		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

SA 08 030 1966

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 Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee

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.