

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER
427-62-034022

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 0000 Registrar's No. 427

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY CAPE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY CAPE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KINDER (TWP.)		Length of stay in 1b 25 YRS-	c. CITY OR TOWN GRAVE HILL
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gravel Hill		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) _____
3. NAME OF DECEASED (Type or print) First Middle Last JAMES William Slinkard		4. DATE OF DEATH Month Day Year SEPT. 27, 1962	
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 July 29 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER (RET.)		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) BURFORDSVILLE, Mo.
13a. FATHER'S NAME MANUEL SLINKARD		13b. MOTHER'S MAIDEN NAME ELLEN ESTES	12. CITIZEN OF WHAT COUNTRY U.S.A.
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 Address HUBERT W. SLINKARD - Randles, 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) Respiratory Failure			INTERVAL BETWEEN ONSET AND DEATH 1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac Failure			12 hours
DUE TO (c) Cerebro-vascular accident			36 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchiectasis			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 Month, Day, Year a.m. p.m.			
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 Jan 2 / 57 to Sept 27 / 62 and last saw ^{her} him alive on Sept 27 / 62 . Death occurred at 4:15 PM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Walter W. Slinkard, D.O.		22b. ADDRESS Jackson Missouri	22c. DATE SIGNED 9-29-62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE SEPT. 29 1962	23c. NAME OF CEMETERY OR CREMATORY FRIENDS CEMETERY	23d. LOCATION (City, town, or county) (State) ORAN MISSOURI
24. FUNERAL DIRECTOR ADDRESS Bisplinghoff Funeral Home - CHAFFEE, Mo		25. DATE RECD. BY LOCAL REG. 9-29-62	26. REGISTRAR'S SIGNATURE Gene Kasten

OCT 30 1962

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, Mo.

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.