

No. 2  
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-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
**FILED MAY 6 1946 STANDARD CERTIFICATE OF DEATH**

State File No. **14180**

Registration District No. **297**

Primary Registration District No. **6027**

Registrar's No. **43**

1. PLACE OF DEATH:

(a) County **Ray**

(b) City or town **Cowgill Rural Grape Grove**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **/**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
(Specify whether

In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ray** **89**

(c) City or town **Cowgill Rural**  
(If outside city or town limits, write "RURAL")

(d) Street No. **5. Miles South East**  
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **O. L. Slover**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **500-07-2901**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **13**  
year **1946** hour **9** minute **A.** M.

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Anna May Slover**

6. (c) Age of husband or wife if alive **59** years

7. Birth date of deceased **Sept. 6. 1886**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 13** 19**46** to **April 13** 19**46**  
that I last saw him alive on **April 13** 19**46**  
and that death occurred on the date and hour stated above.

8. AGE: Years **59** Months **8** Days **7** If less than one day  
hr. min.

Immediate cause of death: **Cerebral Hemorrhage**

Duration

9. Birthplace **Ray Co. Mo.**  
(City, town, or county) (State or foreign country)

Due to.....

Due to.....

10. Usual occupation **Farming**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business.....

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

12. Name **Aaron Slover**

13. Birthplace **Unknown Tenn.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Person**

15. Birthplace **Unknown Tenn.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ed Stover**

(b) Address **Excelsior Springs, Mo.**

17. (a) **Burial** (b) Date thereon **April 15, 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Richmond, Mo.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

18. (a) Signature of funeral director: **[Signature]**

(b) Address **Richmond, Mo.**

(c) Where did injury occur?.....  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place)

19. (a) **April 14-46** (b) **Martha Jackson**  
(Date received local registrar) (Registrar's signature)

While at work?..... (c) Means of injury.....

23. Signature **O. Kilbourn** (M. D.) **[Signature]**

Address **Cowgill, Mo.** Date signed **7/16/46**

13081  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

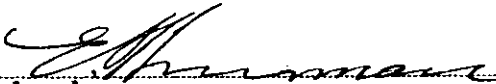
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ###

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed 

Licensed Embalmer No. 2073

P. O. Address Richmond, 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 this body is not embalmed, fact should be so stated above.