N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Lincoln.

Township Ninevah.

or

Village

or

City (NO. , St.; Ward)

Registration District No. 494

Primary Registration District No. ~~494~~ 5658

File No. 16562

Registered No. 2

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Richard Leroy.Shaw.

PERSONAL AND STATISTICAL PARTICULARS

SEX: M.

COLOR OR RACE: White.

SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*): Single.

DATE OF BIRTH: December (Month) 4 (Day), 1913 (Year)

AGE: 1. yrs. 5 mos. 7 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): None.

BIRTHPLACE (City or town, State or foreign country): Lincoln County.Mo.

PARENTS

NAME OF FATHER: Ernest.Shaw.

BIRTHPLACE OF FATHER (City or town, State or foreign country): Lincoln County.Mo.

MAIDEN NAME OF MOTHER: Leolia.Juggesmeyer.

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Montgomery County.Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C.G.Moseley.M.D.

(ADDRESS) Olney.Mo.

Filed May 13, 1915. W.A. Riddle, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: ~~December.~~ May (Month) ~~4.~~ 12 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec, 4, 1913, to May.12th., 1915, that I last saw him alive on May.12th., 1915, and that death occurred, on the date stated above, at 10.P.M. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease.
Weakness of the Aortic Valve &
dilatation of heart.

157C (Duration) 1 yrs. 5 mos. 7 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) C.G.Moseley.M.D. M. D.

May.12. 1915 (Address) Olney.Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Truxton Mo German Century

DATE OF BURIAL: May 13, 1915

UNDERTAKER: River Bros

ADDRESS: Truxton Mo

PLACE OF DEATH

County

Township
or
Village
or
City (NO. , St.; Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. File No.

Primary Registration District No. Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH
(Month) (Day) 1 (Year)

AGE
yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country)

PARENTS
NAME OF FATHER
BIRTHPLACE OF FATHER
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER
BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed , 191 ,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
(Month) (Day) , 191 (Year)

I HEREBY CERTIFY, that I attended deceased from , 191 ; to , 191 , that I last saw h alive on , 191 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)
(Duration) yrs. mos. ds.

(Signed) M. D.
, 191 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	, 191
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.