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

33700

PLACE OF DEATH

County: Cape Girardeau

Township: D.

or Village:

or City: Cape Girardeau (NO. 26 S. Lorimier St.: 1 Ward)

Registration District No. 125 File No.

Primary Registration District No. 3009 Registered No. 1449

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

FULL NAME: Charles H. Shaw

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

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

DATE OF BIRTH: October (Month) 3 (Day), 1845 (Year)

AGE: 71 yrs. 0 mos. 15 ds.

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

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

BIRTHPLACE (City or town, State or foreign country): Bangor Me.

PARENTS

NAME OF FATHER: James Shaw

BIRTHPLACE OF FATHER (City or town, State or foreign country): dont know

MAIDEN NAME OF MOTHER: Susan Tyler

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dover N. H.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George S. Hanford

(ADDRESS) Cape Girardeau Mo

Filed 10/19, 1916. R. W. Frissell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: October (Month) 18 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from January 7, 1914, to October 18, 1916, that I last saw him alive on October 18, 1916, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

92 A

82 D

(Duration) 3 yrs. ___ mos. ___ ds.

Contributory (SECONDARY): Partial Paralysis of Lower limbs

(Duration) 20 yrs. ___ mos. ___ ds.

(Signed) R F Wichterich M. D.

Oct 18, 1916 (Address) Cape Girardeau 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: Charles City Ia

DATE OF BURIAL: Oct 21, 1916

UNDERTAKER: Walther F & U Co.

ADDRESS: Cape Girardeau Mo

PLACE OF DEATH

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

County.....

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

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred i hospital or institut give its NAME inst 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

....., 1.....
(Month) (Day) (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

....., 191
(Month) (Day) (Ye

I HEREBY CERTIFY, that I attended deceased fr

....., 191....., to ....., 191

that I last saw h.....alive on ....., 191

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs. .....mos.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos.

(Signed) ..... M

....., 191..... (Address) .....

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

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

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

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