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

Do not use this space.

36393

1. PLACE OF DEATH

County: Dade — Registration District No. 237 — File No.

Township: Center — Primary Registration District No. 4144 — Registered No. 20

City: Greenfield (No. ..... St. ..... Ward)

2. FULL NAME: Clyde Shaw

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~: Myrtle Daniel Shaw

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Apr. 24. 1898

7. AGE: Years 29 — Months 7 — Days 24 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY): Dade Co. Mo.

PARENTS

10. NAME OF FATHER: Lewis Shaw

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Missouri

12. MAIDEN NAME OF MOTHER: Delia Johnson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Missouri

14. INFORMANT: Myrtle Daniel Shaw
(Address): Greenfield. Mo.

15. FILED 12-21, 1927 E. C. Ball REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 18 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1927, to Dec 18, 1927, that I last saw him alive on Dec. 14, 1927, and that death occurred, on the date stated above, at 3 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Consumption.

23 A

7 (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Measles.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

0 DID AN OPERATION PRECEDE DEATH? NO DATE OF .....

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Geo L. Weir, M. D

, 19 (Address) Greenfield MO.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, ~~CREMATION, OR REMOVAL~~: Greenfield Cemetery — DATE OF BURIAL: Dec. 19 1927

20. UNDERTAKER: J. W. Ward — ADDRESS: Greenfield. Mo.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH
County Dade — Registration District No. 237 — File No.
Township Center — Primary Registration District No. 4144 — Registered No. 20
City (No. St. Ward)

2. FULL NAME Clyde Shaw
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 3-8, 1928 E. O. Ball REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 18 1927

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Consumption
Lungs
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Measles
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

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*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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