

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

Do not use ink

36767

1. PLACE OF DEATH
 County Atchison Registration District No. 19
 Township Rock Port Primary Registration District No. 4013
 City Rock Port (No. _____) St. _____ Ward _____

2. FULL NAME Oliver James 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-4-1862

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>79</u>	<u>9</u>	<u>3</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Retired
 (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) Marshall Co. Ill.

10. NAME OF FATHER Wm Reid

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

12. MAIDEN NAME OF MOTHER Olga J Spear

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

14. INFORMANT Bearle E. Shaw
 (Address) Rock Port, Mo.

15. FILED 11-7-31 Mary Chamberlain
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-7-1931

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1931, to Nov. 7, 1931, that I last saw her alive on Nov. 7, 1931, and that death occurred, on the date stated above, at 11:45 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis
Organic Heart Lesion
75B
77

CONTRIBUTORY (SECONDARY) 75B (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? Nose
 (Signed) W.C. Chamberlain, M. D.
11-8-1931 (Address) Rock Port 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 Edinwood Cem. DATE OF BURIAL 11-10-1931

20. UNDERTAKER Tracy Bartholomew ADDRESS Rock Port

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

NOV 23 1931

