

JAN 15 1940

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

43893
Do not use this space.

1. PLACE OF DEATH
(a) County Lincoln Registration District No. 191
(b) Township Clinton Primary Registration District No. 5656 Registered No. _____
(c) City Moscow Mills Mo. (d) Street No. _____ St. _____
(e) Length of residence in city or town where death occurred 49 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Allen Scale Shafer
(a) Residence, No. Moscow Mills Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Katie Shafer
7. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 15 1860
8. AGE YEARS 79 MONTHS 1 DAYS 6 If LESS than 1 day,hrs. ormin.
9. TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SAWYER, BOOKKEEPER, ETC. Retired saw mill man
10. INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS SAW MILL, BANK, ETC. _____
11. DATE DECEASED LAST WORKED AT THIS OCCUPATION (MONTH AND YEAR) _____ 11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison North Carolina
13. NAME James Shafer
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina
15. MAIDEN NAME Sallie Ann Clark
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina
17. INFORMANT (ADDRESS) Katie Shafer Moscow Mills Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Troy Cemetery DATE Dec 23 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wayne McCoy Troy Mo.
20. FILED Dec 26 1939 Mrs Pearl Muck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 21 1939
22. I HEREBY CERTIFY, That I attended deceased from 11-24, 1939, to 12-21, 1939
I last saw him alive on 12-21-39, 19..... Death is said to have occurred on the date stated above, at 3:00 A.M.
The principal cause of death and related causes of importance were as follows:
Perforated Gastric ulcer Date of onset 11-24-39
Myocarditis chronic
Hepatitis chronic
Arterial Hypertension
Cholelithiasis
Name of operation _____ Date of 11-24-39
What test confirmed diagnosis? _____ Was there an autopsy? _____
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) W.S. Harris, M. D.
(Address) Troy Mo.

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.

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,

....., or by

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.