

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15692

State File No. _____

Registration District No. 653

Primary Registration District No. 5864

Registrar's No. 23

1. PLACE OF DEATH:
 (a) County Pemiscot
 (b) City or town Hayti Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 15 years
years, months or days)

3. (a) PRINT FULL NAME William Walter Shaw
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Corea Shaw 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 21 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 0 7 hr. _____ min.

9. Birthplace Humphrey Co. Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation farming

11. Industry or business farm

12. Name dont know

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name dont know
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James Shaw

(b) Address Hayti Mo.

17. (a) burial (b) Date thereof 3/30/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kennett Mo.

18. (a) Signature of funeral director Ray Undertaking Co.

(b) Address Hayti Mo.

19. (a) 3/29/40 (b) Pearl Kelley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pemiscot
 (c) City or town Hayti Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28
 year 1940 hour 1:40 minute _____ M.

21. I hereby certify that I attended the deceased from I did not attend him, he died a few 19____
minutes before I saw him
 and that death occurred on the date and hour stated above.

Immediate cause of death Some Organ Heart Disease
 Duration _____

Due to Not known Suddenly

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
 Of operations _____

Of autopsy None
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature W.P. Lindbergh (M. D. or other) _____

Address Hayti Mo. Date signed 3/29/40

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.....

Jack Kelley
.....
working under my personal supervision.

....., Registered Apprentice No.....

Signed *Jack Kelley*
.....

Licensed Embalmer No. *3788*
.....

P. O. Address *Hopt. mo.*
.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **15892**

Registration District No. **653**

Primary Registration District No. **3864**

Registrar's No. **23**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Peru**
(b) City or town **Peru T.P.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Wm. Walter Shaw**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **w**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **Mar-21-1885**
(Month) (Day) (Year)

8. AGE: Years **55** Months **56** Days **0** 7 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Mar** day **28**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature **W. P. Limbaugh** M. D. or other _____

Address **Peru** Date signed _____

SUPPLEMENTARY

