

Registration District No. 197

Primary Registration District No. 5276

Registrar's No.

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Rural, Gallatin Mo.
(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: 2
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME: OSCAR H. SHAFER 165
3. (b) If veteran, name war:
3. (c) Social Security No.:

4. Sex: M 5. Color or race: W, W
6. (a) Single, widowed, married, divorced, single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive years

7. Birth date of deceased: May 17 1925
(Month) (Day) (Year)

8. AGE: Years 17 Months 2 Days 29
If less than one day hr. min.

9. Birthplace: Kansas City Mo. O.
(City, town, or county) (State or foreign country)

10. Usual occupation: Student

11. Industry or business:

MOTHER FATHER
12. Name: Manual O. Shafer
13. Birthplace: Unknown Kansas
(City, town, or county) (State or foreign country)
14. Maiden name: Anna Mae Cook
15. Birthplace: Unknown Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant: Wm Shafer

(b) Address: P.O. Box 824, Highland Mo.

17. (a) Burial (b) Date: Aug 17, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Washington, Mo.

18. (a) Signature of funeral director: John S. Merton

(b) Address: 832 Arrow Rd, No. 16 Mo.
19. (a) 8-16-40 (b) John S. Merton
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Platte
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: Parkville - No. R 2
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug, Day: 16
year: 1940 hour: 1:00 minute: A. M.

21. I hereby certify that I attended the deceased from:
Coroner, 19...;
that I last saw him alive on: 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture of Skull
Due to: Automobile Accident ✓

Due to:
Other conditions: Broken Left Arm
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:
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): Accident

(b) Date of occurrence: Aug 16 - 1940

(c) Where did injury occur?: #16 Highway 3 miles north of
(City or town) (County) (State)

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

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

23. Signature: Mrs. W. S. Merton
Address: Liberty Chapel, Mo.

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

4

210 m
98

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-10-40

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.....
Harold L. Ross

Licensed Embalmer No. 3605

P.O. Address. *North Keena*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 197

Primary Registration District No. 5276

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Clay

(b) City or town Ballwin
(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 _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Oscar H. Shaber

3. (b) If veteran, name war G

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 17 Months 2 Days 29 If less than 1 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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

I last saw him _____ alive on _____ 19____

That death occurred on the date and hour stated above.

Immediate cause of death Fracture skull

Automobile accident

Due to _____

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

Major findings: IPM

Of operations _____

Of autopsy _____

Duration 8

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? State maintained highway (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? With another auto. (Specify type of place) _____

What was the means of injury? driving (e) Means of injury _____

23. Signature Mrs W. B. Wynn Corner (M.D. or other) _____

Address _____ Date signed _____

5276

