

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH /

State File No. **28614**

Registration District No. **347** Primary Registration District No. **3018** Registrar's No. _____

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 years, months or days

8. (a) PRINT FULL NAME James W Shawman
8. (b) If veteran, name war _____ 3. (c) Social Security No. 550

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Anna Shawman 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 31 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Henry Co Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Laborer

11. Industry or business _____
12. Name James Shawman
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Anderson
15. Birthplace Anderson Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Shawman
(b) Address Clinton Mo

17. (a) Burial (b) Date thereof 8 17 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hickory Grove

18. (a) Signature of funeral director Fred Wilbur
(b) Address Clinton Mo
19. (a) 8-17-40 (b) _____
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 8 day 12
year 1940 hour 11 minute 00 A. M.
21. I hereby certify that I attended the deceased from about
Jan 2, 1940, to Aug 12, 1940;
that I last saw him alive on Aug 11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary disease
Mitral disease
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations None
Of autopsy None

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? 212
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature E. O. Peltor (M. D. or _____)
Address Clinton Mo Date signed 8/12/40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

2
4
2

5

DEC 6 1949

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1361

Date Filed 9-16-40

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 Fred Wilkinson
Licensed Embalmer No. 2478
P. O. Address Clinton 5th

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

State File No. 28614

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton
(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 _____
years, months or days)

3. (a) PRINT FULL NAME James W Showman

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 m

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

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

8. AGE: Years 70 Months 7 Days 11 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Forest Wilkinson

(b) Address Clinton

19. (a) Aug. 19, 1940 (b) Ed C Peclar (Registrar's signature)
(Date received local registrar)

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 8 day 12
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 _____

Duration

Due to _____

Due to _____

Other conditions _____
(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) _____

(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 Ed C Peclar (M. D. or other) _____

Address Clinton Date signed _____

SUPPLEMENTAL

