

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FILED MAY 15 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13464
1445
Registrar's No.

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kan City
(c) Name of hospital or institution: 2437-27th Cong St 1
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 70 years

3. (a) PRINT FULL NAME

William R. Shafer

3. (b) If veteran, name war No

3. (c) Social Security No. No.

4. Sex Male

5. Color White

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 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days unk If less than one day
hr. _____ min. _____

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

10. Usual occupation Janitor

11. Industry or business Genius Hospital

12. Name James Shafer

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

14. Maiden name Margaret Reynolds

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

16. (a) Informant's own signature Harry Shafer

(b) Address 1021 Jefferson

17. (a) Burial (b) Date thereof 4-12-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation T. S. DEKA - KAN

18. (a) Signature of funeral director BERNMAN-FUNERAL

(b) Address 4206-27th and 28th Sts

19. (a) Apr 10, 1941 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Jackson
(c) City or town Kan City
(If outside city or town limits, write "RURAL")
(d) Street No. 2437-27th Cong St
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9
year 1941 hour 9:10 minute 00 P.M.

21. I hereby certify that I attended the deceased from Apr 8/41
to Apr 9, 1941

that I last saw him alive on Apr 8, 1941

and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction

Due to Arteriosclerosis

Due to _____

Other conditions 948
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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? Home

(Specify type of place) _____

(e) Means of injury _____

23. Signature M. M. Crowe M.D. (M. D. or other)

Address 1303 Walnut St Date signed 4/10/41

Duration 1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr Stipe
Hald Kern Berg.

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: Harry Bergman

Licensed Embalmer No. 2041

P. O. Address Kan City, 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.