

FILLED NOV 27 1941

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

38907
Do not use this space.

1. PLACE OF DEATH

(a) County Morgan Registration District No. 971
(b) Township Mill Creek Primary Registration District No. 4578
(c) City St. Louis (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 7343

2. PRINT FULL NAME

Esther Elnora Shane

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. ~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OR (OR) WIFE OF John R. Shane

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July, 7th, 1913

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
28 4 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. Home
10. Date deceased last worked at this occupation (month and year) 11-15-41 11. Total time (years) spent in this occupation -

12. BIRTHPLACE (CITY OR TOWN) Oxford (STATE OR COUNTRY) Nebraska

FATHER 13. NAME Erich Kellner

14. BIRTHPLACE (CITY OR TOWN) Oxford (STATE OR COUNTRY) Nebraska

MOTHER 15. MAIDEN NAME Fredricka Kellner

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) J. R. Shane

18. BURIAL, CREMATION, OR REMOVAL PLACE Syracuse Co. M. DATE 11-18-1941

19. FUNERAL DIRECTOR (NAME) James E. Richard (ADDRESS) Syracuse Mo.

20. FILED Nov 20, 1941 Omie E. Corby Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 16, 1941

22. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1941, to Nov 16, 1941

I last saw her alive on November 15, 1941. Death is said to have occurred on the date stated above, at 1.2 a. m.
The principal cause of death and related causes of importance were as follows:

Angina Pectoris
7.atty Heart
Excessive Obesity

Date of onset Oct 15, 41

Other contributory causes of importance: 948

Name of operation _____ Date of _____
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) Theodore William Doll, M.D.
(Address) Syracuse Missouri

N. E.—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.

RECEIVED

District Health Officer No. 7,

District File Number 11-41-1936

Date Filed 11-26-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~was~~ ^{will be} embalmed by me, Me

Registered Apprentice No. _____

working under my personal supervision.

Signed

Jesse E. Richard
Licensed Embalmer No. 2466
P. O. Address Lipton, N

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

Registration District No. 971

Primary Registration District No. 4578

Registrar's No. _____

1. PLACE OF DEATH

- (a) County Marion
 - (b) City or town Springfield
(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

2. USUAL RESIDENCE OF DECEASED:

- (a) State MISSOURI (b) County MORGAN
- (c) City or town BYRGOUSE MO. RFD.
(If outside city or town limits, write "RURAL")
- (d) Street No. _____
(If rural, give location)
- (e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Cathie C. Shames

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

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 live _____ years

7. Birth date of deceased _____

July
(Month)

7
(Day)

1946
(Year)

8. AGE:

Years 28

Months _____

Days 4

(if less than one day)

hr. _____ 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) 11/20/41 (b) _____

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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? _____
(Specify type of place)
- While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-38907