

FILED APR 15 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11826

Registration District No. 7164

Primary Registration District No. 4461

Registrar's No.

73
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Roscoe Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 11/24 of 2 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

(c) City or town Roscoe
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ALZORA Shanafelt

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 17 year 1942 hour 2:15 minute P M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Peter Shanafelt 6. (c) Age of husband or wife if alive ded years

7. Birth date of deceased: May (Month) 28 (Day) 1860 (Year)

21. I hereby certify that I attended the deceased from Jan 1 1935 to Feb 1st 1942 that I last saw her alive on Feb 1st 1942 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

81 10 20 hr. min.

Immediate cause of death: Chr. Myocarditis

Due to _____

Due to _____

9. Birthplace Colo Co, Ill (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

Major findings: Of operations none Of autopsy none

11. Industry or business none

12. Name Philip B Clauson

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

14. Maiden name Sarah Caldwell

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

PHYSICIAN 930

Underline the cause to which death should be charged statistically.

16. (a) Informant Gene Pace

(b) Address Roscoe

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-42 (Month) (Day) (Year)

(c) Place: burial or cremation Roscoe Home

18. (a) Signature of funeral director Roscoe Home

(b) Address Roscoe, Mo

19. (a) 3-21-42 (Date received local registrar) (b) 713 Goodrich (Registrar's signature)

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 Merletanish (M. D. or other) MD

Address Tausus City, Kans. Date signed 3/20/42

RECEIVED

District Health Officer No. 7,

District File Number 4-42-399

Date Filed 4-14-42

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 F. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address. Oscoda, Mich.

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.