

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH: **Buchanan**

(a) County **Buchanan**

(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1213 North 10th St /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 years** (Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")

(d) Street No. **1213 North 10th St**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Charles T. Shaw**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **Male** 5. Color or **white** (a) Single, widowed, married, divorced, widower

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

7. Birth date of deceased **Dec 26 1859**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	2	8	hr. min.

9. Birthplace **Unionville, Mo.** (City, town or county) (State or foreign country)

10. Usual occupation **retired farmer**

11. Industry or business _____

12. Name **Benjamin Shaw**

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

14. Maiden name **Martha Lewis**

15. Birthplace **New Jersey** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Abbie Dotson**

(b) Address **615 No. 10th St. St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **2-6-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Tracy Barry Funeral Home**
218 South 10th St

18. (a) Signature of funeral director **Camille Unsworth**

(b) Address **2-6-43** (c) **Rae DeLong**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **4** year **1943** hour **4** minute _____ P. M.

21. I hereby certify that I attended the deceased from **Sept 15, 1942 to Feb 4, 1943** that I last saw him alive on **Feb 1, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration 12 hrs

Due to **Arterio Sclerosis**

Due to _____

Other conditions **Chronic nephritis**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **1316**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **none**

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

23. Signature **J. R. Elliott** (M.D. or other)

Address **801 E. Jones St. St. Joseph, Mo.** Date signed **Feb 5-43**

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

MOTHER FATHER

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

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..... *Gene Clark*
..... Licensed Embalmer No. *4216*
..... P. O. Address. *Savannah*

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.)