

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11178

ED APR. 7. 1943

Registration District No. 292

Primary Registration District No. 4434

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ralls
(b) City or town Center
(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 Life years, months or days

3. (a) PRINT FULL NAME Andrew Josephus Shaw

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Shaw 6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Sept 8 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Ft. Leavenworth Kans
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Odd Jobs

MOTHER { 12. Name Wm Shaw
13. Birthplace Kans
(City, town, or county) (State or foreign country)

FATHER { 14. Maiden name Angeline Hamilton
15. Birthplace Kans
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Shaw
(b) Address Center Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-43
(Month) (Day) (Year)
(c) Place: burial or cremation Union Chapel

18. (a) Signature of funeral director Geo. R. Hulse
(b) Address Center Mo

19. (a) 3-5-43 (Date received local registrar) (b) Mrs. Eual Perkinson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ralls
(c) City or town Center
(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? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2nd
year 1943 hour 4 minute 15p M.

21. I hereby certify that I attended the deceased from July 2, 1942, to Mar. 2, 1943
that I last saw him alive on Feb. 9, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Angina pectoris Duration 2 weeks

Due to Chronic Hypertension 7 yrs

Due to unknown

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy none

Duration

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 _____

28. Signature C. H. Brooker (M. D. or other) MD
Address Center, Mo Date signed 3/5/43

RECEIVED

Dist. Health Comm No 10

Dist. File No. 4-43-629

Date Filed APR 6 1969

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 Bias R. Huen

Licensed Embalmer No. 3856

P. O. Address.....

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.