V. S. No. 2
100M—2-43
Rev. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28006

SEP 7 1943

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 304

24

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 1 mos., 12 days (Specify whether
In this community 1 mos. 12,days
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999

(a) State Iowa (b) County ? 13

(c) City or town Sioux City 0
(If outside city or town limits, write "RURAL")

(d) Street No. 617 Iowa St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME S MAX C. SHAW

3. (b) If veteran, name war World War I

3. (c) Social Security No. Yes, not remembered

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Delia Grace Shaw

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Nov. 16, 1901
(Month) (Day) (Year)

8. AGE: Years 41 Months 8 Days 14 If less than one day ___ hr. ___ min.

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

10. Usual occupation Mechanic - unemployed

11. Industry or business "

FATHER
12. Name Eugene Shaw
13. Birthplace - Iowa
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sue Hardenbrook
15. Birthplace - Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration, Excelsior Springs, Mo.
(b) Address

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-31-43
(Month) (Day) (Year)

(c) Place: ~~burial or cremation~~ of removal Cedar Falls, Iowa

18. (a) Signature of funeral director HERBERT HOPE,
(b) Address Excelsior Springs, Mo.

19. (a) 7-31-43 (Date received local registrar) (b) Mrs. Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30 Year 1943 hour 9:45 minute A. M.

21. I hereby certify that I attended the deceased from June 18, 1943 to July 30, 1943 that I last saw him alive on July 30, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis, pulmonary, chronic active 4-severe, far advanced	uhknown
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13 bl

Major findings:
Of operations
Of autopsy No 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: FORREST G. BELL, M. D. (M. D. or other)

Address Veterans Administration Excelsior Springs, Mo. Date signed 7-

1166

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-3-43

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 J. A. Moles

Licensed Embalmer No. 3296

P. O. Address Ex Spg 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, fact should be so stated above.