

FILED NOV 9 1943/2

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000

1. PLACE OF DEATH:  
(a) County Buchanan,  
(b) City or town Saint Joseph,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Methodist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 hours,  
In this community 55 yrs. 9 mos. 3 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Marie P. Shaw,  
3. (b) If veteran, name war None, 3. (c) Social Security No. None,

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Oscar Shaw, 6. (c) Age of husband or wife if alive 67 years  
7. Birth date of deceased: January 15th 1888  
(Month) (Day) (Year)

8. AGE: Years 55 Months 9 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Joseph, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation At Home,

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name George S. Arnhold,  
13. Birthplace Unknown, Germany, (City, town, or county) (State or foreign country)  
14. Maiden name Mary Carpenter,  
15. Birthplace Unknown, Germany, France (City, town, or county) (State or foreign country)

16. (a) Informant Oscar Shaw  
(b) Address 1923 No. 3rd. Street, St. Joseph, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10/22/43 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora

18. (a) Signature of funeral director Newton B. Bell & Co.

(b) Address 319 So. 10th. Street, St. Joseph, Mo.

19. (a) 10/20/43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri, (b) County Buchanan  
(c) City or town Saint Joseph, (If outside city or town limits, write "RURAL")  
(d) Street No. 1923 North 3rd. Street (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 18th  
year 1943 hour 1:00 minute 23 a.m.

21. I hereby certify that I attended the deceased from Jan 3, 1939, to October 18, 1943  
that I last saw her alive on October 18, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Asliosis chronic general, hypertension  
Duration ?

Due to Cerebral hemorrhage 1 day  
Due to hemiplegia right

Other conditions Retinal hemorrhage  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN J. J. J.  
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 \_\_\_\_\_

23. Signature J. J. J. (M. D. or other) \_\_\_\_\_  
Address St. Joseph, Mo. Date signed 10-19-43

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

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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

*Emur Thomas*

Licensed Embalmer No.

*2640*

P. O. Address

*St Joseph 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.**