

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38901**

FILED DEC 7 1943
Registration District No. **7916**

Primary Registration District No. **5947**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Phelps**
(b) City or town **St James Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Soldiers Home 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 yrs** (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Phelps**
(c) City or town **St James Mo**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **6**
year **1943** hour **1:30** minute **a** M.

21. I hereby certify that I attended the deceased from **Jan 1942** to **11/8/43**
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic int nephritis 3 yrs**

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: **131a**

Of autopsy: _____

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? _____ Means of injury _____

23. Signature **W. L. Green** (M. D. or other) _____
Address **St James Mo** Date signed **11/8/43**

3. (a) PRINT FULL NAME **Maggie Shaw**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Wid 2**

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

7. Birth date of deceased: **12-25-1856**
(Month) (Day) (Year)

8. AGE: Years **86** Months **10** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **New York** (City, town, or county) **N.Y.** (State or foreign country)

10. Usual occupation **house wife**

11. Industry or business _____

12. Name **Don't Know**

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

14. Maiden name _____

15. Birthplace **Don't Know** (City, town, or county) **"** (State or foreign country)

16. (a) Informant **Soldiers Home record**

(b) Address **St James Mo**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **11-6-43** (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem St James Mo**

18. (a) Signature of funeral director **W. P. Schuler**

(b) Address **St James Mo**

19. (a) **11-8-43** (Date received local registrar) (b) **Charles D. [unclear]** (Registrar's Signature)

1091 (Licensed Embalmer's Statement on Reverse Side)

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

Duration

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.....

W. E. Licklider....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *W. E. Licklider*.....

Licensed Embalmer No. *1930*.....

P. O. Address *St James 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.