

Registration District No. 42 Primary Registration District No. 1000

**1. PLACE OF DEATH:**  
(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:  
1909 Spratt Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 1 year  
years, months or days

**3. (a) PRINT FULL NAME** Clara J. Shetler  
3. (b) If veteran, name war L 3. (c) Social Security No. L

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Winfield S. Shetler 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased December 27 1957  
(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day  
86 3 28 hr. \_\_\_\_\_ min.

9. Birthplace Canton, Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

**MOTHER FATHER**  
11. Industry or business \_\_\_\_\_  
12. Name Josiah Bash  
13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. C. Smith  
(b) Address St Joseph Mo

17. (a) removed (b) Date thereof 4/26/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St John Kansas

18. (a) Signature of funeral director Heaton, BeGore & Bowman  
(b) Address St Joseph Mo

19. (a) 4/25/44 (b) Arce Heitz  
(Date received local registrar) (Registrar's signature)

**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. 1909 Spratt  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month April day 25  
year 1944 hour 6 minute 4 A. M.  
21. I hereby certify that I attended the deceased from Mar 23, 1944  
to April 24, 1944, to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw her alive on April 24th 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute hypostatic Pneumonia 3 days  
Due to Fracture of right thigh 1 mo.  
Due to Senility and Cardiovascular degeneration 1 year  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration

**PHYSICIAN**

Major findings: \_\_\_\_\_  
Of operations: no  
Of autopsy: no

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 H. F. Mundy (M. D. or other) \_\_\_\_\_  
Address 404 So 3rd St Date signed 4/25/44

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

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. may

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 413

1. PLACE OF DEATH:

(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:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether

In this community  
years, months or days)

3. (a) PRINT FULL NAME Clara J. Shetter

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

4. Sex 3 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive.

7. Birth date of deceased. Dec 27 1885  
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 1 (If less than one day, min.)

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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 April 1948 year. 10 hour 25 minute M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death acute Hypertension Duration 3 days

Due to fracture of right thigh 1 mo.

Due to Sensibility of Cardiovascular degeneration 1 yr

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations 160

Of 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) accident

(b) Date of occurrence Mar 23-1944

(c) Where did injury occur? St Joseph Buch Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

In the home  
While at work? no (Specify type of place) (e) Means of injury Fall on floor

23. Signature H. F. Munday (M. D. or other)

Address 404 So 9th St Date signed 5/15/44

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

SUPPLEMENTAL

BUREAU OF CENSUS

12-4 MAY 17 PM 3 5

ADMINISTRATIVE SERVICES  
DIVISION

14202

MEDICAL EXAMINER  
MAY 15 1944  
ST. JOSEPH, MO.