

FILED MAY 9 1944

Registration District No. _____

Primary Registration District No. 5428

1. PLACE OF DEATH:

(a) County FRANKLIN
(b) City or town JESSEN MOORE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
FRANKLIN COUNTY, LESLIE, MO
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 4 years

8. (a) PRINT FULL NAME ESTHER MARY SHAW

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife WILLIAM G. SHAW 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 28 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 81 1 3 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name JAMES BYRNES
13. Birthplace Ireland (City, town, or county) (State or foreign country)
14. Maiden name ANN FARRINGTON
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant T. Mc Williams
(b) Address FRANKLIN COUNTY, LESLIE, MO.
17. (c) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-1944 (Month) (Day) (Year)
(c) Place: burial or cremation ST. PETERS Cem. Kirkwood Mo

18. (a) Signature of funeral director L. H. Bogg Ins
(b) Address 131 W. Argonne Dr. Kirkwood, Mo
19. (a) 4-3-44 (Date received local registrar) (b) Do Overman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County FRANKLIN
(c) City or town RURAL (If outside city or town limits, write "RURAL")
(d) Street No. FRANKLIN COUNTY LESLIE, MO (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1 year 1944 hour 10 minute 10 P. M.

21. I hereby certify that I attended the deceased from January 10, 1944, April 1, 1944 that I last saw her alive on March 31, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic cardio-vascular renal disease. Duration _____

Due to _____
Due to 13/a
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations No ~~HEMORRHOID~~ operation
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? _____

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature J. F. Marshall MD (M.D. or other)
Address Beaufort, Missouri Date signed 4-2-44

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-8-44

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. 4343

P. O. Address 7115 Zephyr Pl.
Mableton, Ga.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 690

Registration District No. 112

Primary Registration District No. 5428

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

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Paris (If outside city or town limits, write "RURAL" and name of township) Lyon Twp
(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 (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Esther Mary Shaw

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

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

6. (b) Name of husband or wife William E Shaw 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 28 1886
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day _____ min.

9. Birthplace Mo.
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) [Signature]
(Date received local registrar) (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 Day _____ Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

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) _____

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

14 Cell

Don Owen
Shald, mo