

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

FILED APR 19 1944

State File No.

Registration District No. 170

Primary Registration District No. 5627

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Abbe (Rural) Frankl
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Hosp
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede ⁵³

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

(d) Street No. Abbe
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country..... ⁰

3. (a) PRINT FULL NAME WILLIAM DAVID SHIVERS

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
year 1944 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from 3/22, 1944, to 3/23, 1944;
that I last saw h.i.m. alive on 3/23, 1944;
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Zelphia Ora Ann Jeffers alive..... years

6. (c) Age of husband or wife if 12 years

7. Birth date of deceased Oct. 18 1860
(Month) (Day) (Year)

Immediate cause of death Bilateral Lower Lobar Pneumonia Duration 1 wk.

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

83 5 11 hr. min.

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

10. Usual occupation Farmer

Due to.....

Due to.....

Other conditions Auricular Fibrillation ?
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business.....

12. Name John Shivers

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

14. Maiden name Syntha Sellers

15. Birthplace John ¹
(City, town, or county) (State or foreign country)

Major findings: Of operations..... 108

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Oliver J Shivers

(b) Address Dry No 1 no.

17. (a) Burial (b) Date thereof 3-25-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Roads

18. (a) Signature of funeral director W.E. Helman

(b) Address Lebanon Mo.

19. (a) April 3-44 (b) Grace Rapp
(Date received local registrar) (Registrar's signature)

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 John W. Beshaw, M.D. (M. D. or other) ⁰
Address Laclede County Health Unit, Date signed 3/27/44

1090

Lebanon Mo.

Received

Laclede County Health Unit

File No. 3-44-36

Date Filed 4/18/47

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon 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.