

No. 2  
-2-43  
17-39  
X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15517  
Registrar's No. 2

FILED MAY 8 1944  
Registration District No. 2580

Primary Registration District No. 5960

1. PLACE OF DEATH:  
(a) County Platte  
(b) City or town Greenburg  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
In this community 87 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Platte  
(c) City or town Carden Point Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Apr. day 17th.  
year 1944 hour 4 minute A M.

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife deceased  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased January 29 1857  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1st, 1944 to April 17th, 1944  
that I last saw him alive on April 8th, 1944  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
87	2	18	hr. _____ min.

Immediate cause of death Chronic Myocarditis 5 years  
Duration \_\_\_\_\_

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

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 928

10. Usual occupation Farrer  
11. Industry or business Farming

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER { 12. Name Joseph Shaw  
FATHER { 13. Birthplace Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Missouri Ketner  
15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Rella St. John  
(b) Address Carden Point Missouri

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? \_\_\_\_\_

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/1944  
(Month) (Day) (Year)  
(c) Place: burial or cremation Carden Point Cem

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
23. Signature S. T. Dush (M. D. or \_\_\_\_\_)  
Address Dearborn Mo Date signed 4-20-44

18. (a) Signature of funeral director R. W. Davis  
(b) Address Dearborn Missouri  
19. (a) 4/18/44 (Date received local registrar)  
(b) Mrs. Clay Riffe (Registrar's signature)

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

**RECEIVED**

District Health Officer No. \_\_\_\_\_

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

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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 Russian Davis

Licensed Embalmer No. 4160

P. O. Address Seaborn 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.**