

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

22243
Do not use this space.

FILED JUL 11 1944

1. PLACE OF DEATH *Pettis* 800 Registration District No. *274*
 (a) County *Pettis* or City *Green Ridge* Primary Registration District No. *4405*
 (b) Township *Green Ridge* (d) Street No. _____ St. _____
 (c) City _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *Walter Scott Shaw spent his entire life except a couple of years in Pettis Co*
 (a) Residence, No. *Green Ridge Mo* St. (if nonresident, give city or town and State) *Mo*
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Apr-6-1859*

7. AGE YEARS *85* MONTHS *2* DAYS *104* If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *FARMER*

9. Industry or business in which work was done, as saw mill, bank, etc. *Farmed all his life.*

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) *Hess Creek, Miss.* (STATE OR COUNTRY) *Pettis Co Mo*

13. NAME *W.B. Shaw*

14. BIRTHPLACE (CITY OR TOWN) *Memphis* (STATE OR COUNTRY) *Tenn*

15. MAIDEN NAME *Redd*

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT *L. B. Shaw, son* (ADDRESS) *Green Ridge, Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Green Ridge* DATE *June 13 44*

19. FUNERAL DIRECTOR (NAME) *L. L. Reams* (ADDRESS) *Green Ridge Mo*

20. FILED *6-11-44* *Ans Arma Berger* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *6-10-1944*

22. I HEREBY CERTIFY, That I attended deceased from *June 7, 1944, to June 10, 1944*
 I last saw him alive on *June 2, 1944* Death is said to have occurred on the date stated above, at *8 A. m.*
 The principal cause of death and related causes of importance were as follows:
Angina Pectoris

Other contributory causes of importance *g4 h*

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) *H. A. Hite*, M. D.
 (Address) *Green Ridge, Mo*

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 7-19-14

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. ~~1881~~
working under my personal supervision.

Signed.....

L. L. Ream

Licensed Embalmer No. 1881

P. O. Address Green Ridge 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, above space should be left blank.