

FILED NOV 13 1944

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 709 Washington  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community unknown  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Jackson City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 709 Washington  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HARRY SHIDLER

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

4. Sex Ma 5. Color W 6. (a) Single, widowed, married, divorced unknown  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased unknown  
(Month) (Day) (Year)

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

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

10. Usual occupation unknown

11. Industry or business unknown

12. Name unknown

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 Coroner's Office

(b) Address K.C. Mo

17. (a) Removal (b) Date thereof 10/26/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Catholic Church

18. (a) Signature of funeral director J. E. Brown

(b) Address K.C. Mo

19. (a) 10-27-44 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23  
year 1944 hour 6:40 minute \_\_\_\_\_ a. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Deputy Coroner

Immediate cause of death \_\_\_\_\_

Coronary Arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 94a  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_  
Of autopsy inspection & history

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 A. E. Webster (M. D. or other) \_\_\_\_\_

10/25/44  
Address 68 Meloy Date signed \_\_\_\_\_

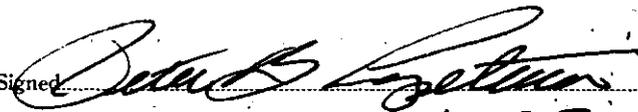
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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.....

4723

P. O. Address.....

125 No

**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.**