

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 3 1944

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1075

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Nursing Home, 1401 Jules St. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months
(Specify whether _____)

In this community about 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 5002 1/2 King Hill Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph Elias Shaffer

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White

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

6. (b) Name of husband or wife Hallie Shaffer

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

7. Birth date of deceased April 26, 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>5</u>	<u>29</u>	_____ hr. _____ min.

9. Birthplace Mason City, Nebraska 1
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Boiler maker

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Vera Taylor

(b) Address 515 E. Missouri Ave.

17. (a) Burial (b) Date thereof Oct. 27, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Auburn Cemetery

18. (a) Signature of funeral director Robert M. ...

(b) Address 5025 King Hill Ave.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25
year 1944 hour 11 1/2 minute 00 a a M.

21. I hereby certify that I attended the deceased from Oct 25, 1944 to Oct 25, 1944
that I last saw him in alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Aortic Insufficiency
Endocarditis chronic

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) (c) Means of injury _____

23. Signature Dr. John Kartsch (M.D. or other) D.O.
Address 2224 1/2 Logan Bldg Date signed Oct 26 44

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

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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 10-25-44

....., Registered Apprentice No.
working under my personal supervision.

Signed Embalmer

Licensed Embalmer No. 4225

P. O. Address St. Joseph, 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.