

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 25 1945  
Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

Registrar's No. 5

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

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: 624 POPLAR  
(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 MO. (b) County GREENE 39

(c) City or town SPRINGFIELD  
(If outside city or town limits, write "RURAL") 6

(d) Street No. 624 POPLAR  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME GEORGE ANDREW SHANE

3. (b) If veteran, NONE name war \_\_\_\_\_

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 1  
year 1945 hour 4 minute 15 P.M.

4. Sex MALE 5. Color of race WHITE

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

6. (b) Name of husband or wife VIOLA L. SHANE

6. (c) Age of husband or wife if alive, 63 years  
may (Month) 11 (Day) 1873 (Year)

7. Birth date of deceased \_\_\_\_\_

21. I hereby certify that I attended the deceased from Dec 24, 1944, to Jan 1, 1945  
that I last saw him alive on Jan 1, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death gang - 4:15 PM Duration \_\_\_\_\_

8. AGE: Years 71 Months 7 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to acute Bronchial Pneumonia

Due to Bronchial Coll

Other conditions acute valvular heart lesion  
(Include pregnancy within 3 months of death)

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

10. Usual occupation CUSTODIAN OF BLDG.

11. Industry or business CUSTODIAN

12. Name JOHN W. SHANE

13. Birthplace UNK. VA.  
(City, town, or county) (State or foreign country)

14. Maiden name L. UNK.

15. Birthplace UNK. UNKNOWN  
(City, town, or county) (State or foreign country)

Major findings: no

Of operations \_\_\_\_\_

Of autopsy no

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

16. (a) Informant MAURICE SHANE

(b) Address 230 N. RAMSEY SPRINGFIELD, MO.

17. (a) BURIAL (b) Date thereof Jan 5 - 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cem

18. (a) Signature of funeral director J. W. Ingner & Co.

(b) Address Springfield, MO.

19. (a) 1-4-45 (b) J. W. Ingner  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following: no

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(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? no (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature UF Key (M. D. or other) \_\_\_\_\_  
Address Springfield, MO. Date signed Jan 5

982

4 45

FEB 16 1945

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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 C. G. L. Slone Jr.  
Licensed Embalmer No. 4124  
P. O. Address Springfield

**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.

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