

**FILED** SEP 20 1945

Registration District No. **1** Primary Registration District No. **3000**

**1. PLACE OF DEATH:**

(a) County **Adair**  
(b) City or town **Kirksville, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Laughlin Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 Days**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **MR. Delbert Basil Shaw**

3. (b) If veteran, name war **NO.** 3. (c) Social Security No. **520-03-7323**

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **Alpha Shaw** 6. (c) Age of husband or wife if alive **43** years

7. Birth date of deceased **August 20 1896**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<b>48</b>	<b>11</b>	<b>21</b>	<b>0</b>	hr. min.

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

10. Usual occupation **FARMER**

11. Industry or business

MOTHER { 12. Name **Me James Shaw**  
13. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **ANNA BRANSCOMB**  
15. Birthplace **Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **James Mollanix**  
(b) Address **Worthington, Mo.**

17. (a) **Burial** (b) Date thereof **9-14-1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Pleasant Home Cem**

18. (a) Signature of funeral director **W. Husted & Son**  
(b) Address **Unionville, Mo.**

19. (a) **8/14/45** (b) **Dr. J. Wayman**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Putnam 86**  
(c) City or town **Worthington, Mo.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **0**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **August** day **11** year **1945** hour **8** minute **20 A.M.**

21. I hereby certify that I attended the deceased from **August 7**, 1945, to **August 11**, 1945, that I last saw him alive on **August 11**, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**  
Due to **foreign body (fish bone) in esophagus** Duration **Aug 1-12**

Other conditions (Include pregnancy within 3 months of death)  
Major findings of operations **PH**  
Of autopsy **PH**  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
PHYSICIAN **PH**  
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) **accident**  
(b) Date of occurrence **Aug 18, 1945**  
(c) Where did injury occur? **Worthington, Mo.**  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **home**

(Specify type of place) While at work **no** (e) Means of injury **fish bone**  
23. Signature **Carl Langley** (M. D. or other) **Do**  
Address **Putnam, Mo.** Date signed **8-11-45**

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

FEB 4 1946

RECEIVED  
District Health Officer No. 10  
District File Number 9-45-1443  
Date Filed SEP 17 1945

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

*J. O. Husted*

Licensed Embalmer No.

*2975*

P. O. Address

*Unionville 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *ocp*Registration District No. *1*Primary Registration District No. *3000*Registrar's No. *1852*

## 1. PLACE OF DEATH:

- (a) County *Adair*  
 (b) City or town *Kirksville*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:

(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)3. (a) PRINT  
FULL NAME. *Dilbert B Shan*

3. (b) If veteran,
- 
- name war.

3. (c) Social Security
- 
- No.

4. Sex
- m*
5. Color or race
- w*
6. (a) Single, widowed, married,
- 
- divorced.
- m*

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if
- 
- alive.
- days*

7. Birth date of deceased
- Aug 20 1952*
- 
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- 
- 49 11*
- hr. min.

9. Birthplace
- mo*
- 
- (City, town, or county) (State or foreign country)

## 10. Usual occupation

## 11. Industry or business

12. Name
- 
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
- 
- (b) Address

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Aug*
- Year
- 1952*
- hour
- 11*
- minute
- 15*
- M.

21. I hereby certify that I attended the deceased from
- 1952*
- to
- 1952*

that I last saw h. *alive* on *1952* and that death occurred on the date and hour stated above.  
immediate cause of death. *swallowing fish bone* Duration *6 days*

- Due to
- swallowing fish bone*
- 6 days*
- 
- Due to

Other conditions.  
(Include pregnancy within 3 months of death)Major findings:  
Of operations. *1952*Of autopsy. *19*

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

## 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) *swallowed*  
(e) Means of injury *fish bone*

23. Signature
- Carl Hargel*
- (M. D. or other)
- Dr*
- 
- Address
- Kirksville Mo*
- Date signed
- 9-23-52*

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

SUPPLEMENTARY

MOTHER FATHER

FEB 4 1946

30010