

STANDARD CERTIFICATE OF DEATH

State File No. 31377

FILED OCT 12 1945

Registration District No. 316

Primary Registration District No. 6070

Registrar's No. 147

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

1. PLACE OF DEATH:

(a) County St. Francis
(b) City or town near Cross Roads mo
(c) Name of hospital or institution Liberty Twp. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francis
(c) City or town near Womack mo
(If outside city or town limits, write "RURAL")
(d) Street No. Liberty Twp. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

John Shaw

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex mo

5. Color or race W

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

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

6. (b) Name of husband or wife Laura Shaw

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

7. Birth date of deceased April 10 1867
(Month) (Day) (Year)

8. AGE:

Years 78 Months 4 Days 3
If less than one day
hr. _____ min. _____

9. Birthplace

near Womack, mo
(City, town, or county) (State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER { 12. Name

Joshua Shaw

13. Birthplace

mo.
(City, town, or county) (State or foreign country)

14. Maiden name

Matilda Wath

15. Birthplace

mo.
(City, town, or county) (State or foreign country)

16. (a) Informant

ma John Shaw

(b) Address

near Womack, mo

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8-15-45
(Month) (Day) (Year)

(c) Place: burial or cremation

Cross Roads Cemetery

18. (a) Signature of funeral director

Baldwell Bros

(b) Address

Flat River

19. (a) 9-6-45

(Date received by local registrar)

(b) Esther Rudloff
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13 day aug
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 8-13 1945 to 8-13 1945
that I last saw him alive on 8-13 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcal Meningitis
Duration 5 da.

Due to Streptococcal Meningitis 20 yrs.

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? _____

(Specify type of place) (c) Means of injury _____
While at work? _____

23. Signature Geo. H. Leathers (M. D. or other) _____
Address Farmington mo Date signed 9-6-45

1397

Health Officer No. 4
District File Number 1045-1196
Date Filed 10-9-45

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 W. A. Baldwin

Licensed Embalmer No. 3317

P. O. Address Flat River 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.