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37823

FILED OCT 22 1945

State File No.

Registration District No. 55

Primary Registration District No. 3011

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Wayne

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

(c) Name of hospital or institution:
Ms. Edk. Kern - Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
thirty years (Specify whether years, months or days)

In this community thirty years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

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

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

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

3. (a) PRINT FULL NAME William Marion Shaw

3. (b) If veteran, name war.

3. (c) Social Security No. 17-30

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1
year 1945 hour minute 7:00 A.M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Ms. Susan Shaw

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

7. Birth date of deceased Nov. 21 - 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 15 1945 to Sept 1 1945
that I last saw him alive on Sept 28 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Prisoning

Duration 3 mo.

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>10</u>	<u>10</u>	hr. min.

Due to

Due to

9. Birthplace Howard Co. Mo
(City, town or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Retired farmer

Major findings: Of operations

11. Industry or business

Of autopsy

12. Name Henry Shaw

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

13. Birthplace Howard Co Mo
(City, town or county) (State or foreign country)

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

14. Maiden name Emma Jennings

15. Birthplace Howard Co Mo
(City, town or county) (State or foreign country)

16. (a) Informant Ms. Geo. Jennings

(b) Address Ms. Hale

17. (a) Final (b) Date thereof Oct 2 - 1945
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Carrollton, Wayne Co, Mo

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?

18. (a) Signature of funeral director Hale Mo

23. Signature J. A. ... Address Carrollton, Mo Date signed Oct 1

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1424

41-

RECEIVED

District Health Officer No: 8;

District File Number

Date Filed 10-19-41

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 *Frank E. Slater*

Licensed Embalmer No. *937*

P. O. Address *Hal. Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 18

Registration District No. 55 Primary Registration District No. 3011

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Cavalletter
(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 Wm M Shaw

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 wid

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

7. Birth date of deceased Nov. 21
(Month) (Day) (Year)

8. AGE: Years 89 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace _____
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 Nov Day 21 Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

do not know

Due to Was not following case

Due previously

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy 13

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 B Hamilton (M. D. or other) _____

Address Carroll, Mo Date signed 11-26-44

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

33438