

FILED NOV 30 1945

Registration District No.

Primary Registration District No. 3000

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Grim-Smith Hospital & Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community...
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schulyer
(c) City or town Glenwood
(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

Mrs. Paul Schafer

(b) If veteran, name war No

(c) Social Security No. No

4. Sex female / 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Paul Schafer
6. (c) Age of husband or wife if alive 17 years (Day) (Year)

7. Birth date of deceased: October 17 1912
(Month) (Day) (Year)

8. AGE: Years 33 Months 2 Days 2
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Eugene Mc Goldrick

13. Birthplace Schulyer Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Chambers

15. Birthplace Schulyer Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Mrs. Carter

(b) Address Glenwood, Mo.

17. (a) Burial (b) Date thereof 10-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Home Memorial

18. (a) Signature of funeral director Marcell O. Benton
(b) Address Lincoln Mo

19. (a) 10-30-45 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 19th
year 1945 hour 1:05 P.M. minute 1 M.

21. I hereby certify that I attended the deceased from October 16, 1945 to October 19, 1945
that I last saw her alive on October 19, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular heart disease (congenital) & myocardial failure
Due to.....

Duration 6 mo.

Due to.....

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

3 mo.

Major findings: Of operations None

PHYSICIAN

Of autopsy None

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 George E. Grim (M. D. or other) MD
Address Kirkville, Missouri Date signed 10-22-45

1614

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

RECEIVED

District Health Officer No. 10

District File Number 11-45-1777

Date NOV-27-1945

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

Quirrell O. Fenton

Registered Apprentice No. 3705

working under my personal supervision.

Signed

Quirrell O. Fenton

Licensed Embalmer No. 3705

P. O. Address Lancaster

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.

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirkville Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Grim-Smith Hospital & Clinic
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 da
(Specify whether years, months or days)

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.....

3. (a) PRINT FULL NAME

Flourance Esther Shafer

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

3. (c) Social Security No.....

4. Sex.....
 5. Color or race.....
 6. (a) Single, widowed, married, divorced.....
 6. (b) Name of husband or wife Paul Shafer
 6. (c) Age of husband or wife 35 years
 7. Birth date of deceased.....
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
 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) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 19 1945
year 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
 that I saw him/her alive on.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Duration

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
.....
(Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

