

FILED DEC 30 1945
Registration District No. 93

Primary Registration District No. 5896

Registrar's No. 15

1. PLACE OF DEATH: *Dade*

(a) County *Dade*

(b) City or town *Rural - Center Twp*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *5 miles N. of Greenfield*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *No* (Specify whether years, months or days)

In this community *68 years* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Dade*

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

(d) Street No. *5 miles N. of Greenfield*
(If rural, give location)

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

3. (a) PRINT FULL NAME *EVA LOU SHAW*

3. (b) If veteran, name war *No*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *November* day *25*
year *1945* hour *8* minute *35 A.M.*

4. Sex *Female*

5. Color or race *White*

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

6. (b) Name of husband or wife *Arthur M. Shaw*

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

7. Birth date of deceased *August 2 1877*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Nov 24 1945* to *Nov 25 1945*; that I last saw her alive on *Nov 25 1945* and that death occurred on the date and hour stated above.

8. AGE: Years *68* Months *3* Days *23* If less than one day hr. min.

Immediate cause of death *Diabetic Coma*

Due to *Diabetes Mellitus*

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

Due to _____

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

10. Usual occupation *None*

11. Industry or business *None*

Major findings: Of operations *61*

Of autopsy _____

MOTHER FATHER { 12. Name *Hubbard Johnson*

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

14. Maiden name *Fannie Hoskins*

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

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? _____

16. (a) Informant *Arthur M. Shaw*

(b) Address *Greenfield, Mo.*

17. (a) *Burial* (b) Date thereof *11-27-45*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Greenfield Cemetery*

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

23. Signature *Harshel Shockey* M. D. or other *DO*
Address *Greenfield* Date signed *Mo.*

18. (a) Signature of funeral director *Earl E. Samsen*

(b) Address *Greenfield, Mo.*

19. (a) *11-27-45* (b) *Ed. L. Blair*
(Date received local registrar) (Registrar's signature)

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 James E. Serroney Jr.

Licensed Embalmer No. 4099

P. O. Address Greenfield, 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.