

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37933

State File No.

FILED NOV 16 1945

Registration District No. 210

Primary Registration District No. 5771

Registrar's No. 65

1. PLACE OF DEATH, **MERCER Mercer**

(a) County **MERCER**

(b) City or town **Rural (Marian Twp.)**
(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 _____
In this community **85 years 8 Mo. 18 Days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Mercer 65**

(c) City or town **Rural**
(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 Daniel Shaffer**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **Feb. 6, 1860**
(Month) (Day) (Year)

8. AGE: Years **85** Months **8** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace **Mercer County Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Own Farm**

12. Name **Daniel Shaffer**

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

14. Maiden name **Rachael Goodin**

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

16. (a) Informant **Jane Shaffer**

(b) Address **Mercer Mo.**

17. (a) **Burial** (b) Date thereof **Oct. 26, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **O. C. Greenlee**

(b) Address **Lineville Iowa**

19. (a) **10-30-95** (b) **Evon Martin**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **24**
year **1945** hour **5** minute **_____** P.M.

21. I hereby certify that I attended the deceased from **June 15**, 19 **45** to **Oct 24**, 19 **45**
that I last saw him alive on **Oct 23** and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer prostate gland**
Duration _____
Due to **unknown**

Due to _____

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

Major findings: Of operations **518**
Of autopsy **none**

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? _____

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

23. Signature **O. C. Greenlee MD** (M. D. or other) _____
Address **Lineville Mo** Date signed **10/26/45**

1367 (Licensed Embalmer's Statement on Reverse Side)

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

65
65

2 37

3

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 Amel Grunler
Licensed Embalmer No. 3967
P. O. Address Louisville Louisiana

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.