

STANDARD CERTIFICATE OF DEATH

State File No.

8740

Registrar's No.

88

Registration District No.

53

Primary Registration District No.

3010

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 528 Olive St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 months  
(Specify whether  
In this community 5 months  
years, months or days)

3. (a) PRINT FULL NAME

Sam Shaner

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased

March 1, 1874

(Month) (Day) (Year)

8. AGE:

Years 72

Months 0

Days 9

If less than one day  
hr. min.

9. Birthplace

Old Appleton, Missouri

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

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name John Shaner

13. Birthplace Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. (a) Informant

Miss Dona Shaner

(b) Address

Jackson, Missouri

17. (a)

Burial

(b) Date thereof March 14, 1946

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

Fairmont Cemetery

18. (a) Signature of funeral director

F. J. Sparks

(b) Address

Cape Girardeau, Mo.

19. (a)

3-13-1946

(b)

C. E. Summers

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau  
(c) City or town Old Appleton (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10  
year 1946 hour 10 minute 55 A. M.

21. I hereby certify that I attended the deceased from 2-17-46 to 3-5-46  
that I last saw him alive on 3-5-46 and that death occurred on the date and hour stated above.

Immediate cause of death: Uremic Toxemia Duration 2 mos.  
Chronic Nephritis 4 mos.

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)  
(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 W. A. Lugal (M. D. or other)  
Address 204 S. Locust St. Charleston, Mo. signed 3-12-46

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

District File Number <sup>4</sup> 346-1882

Date Filed 3-23-46

DEC 6 1945

MAR 29 1946

**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 Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Sierran Md

**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.**