

FILED MAR 12 1947

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 54

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

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirksville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Green Smith Hosp. O  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair 105  
(c) City or town Milan Sullivan's  
(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 Shawn Martin Megrew

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 0

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

7. Birth date of deceased 2 9 47  
(Month) (Day) (Year)

8. AGE: Years ; Months Days If less than one day  
4 hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Chas. M. Megrew  
13. Birthplace Milan Mo O  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Catherine Thomas  
15. Birthplace Altamont Mo O  
(City, town, or county) (State or foreign country)

16. (a) Informant Chas Megrew  
(b) Address Milan Mo

17. (a) Burial (b) Date thereof 2 10-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S. Mary's Cem

18. (a) Signature of funeral director Richard

(b) Address Milan Mo

19. (a) 3-6-47 (b) Kate Lambert  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9  
year 47 hour 4 minute 0 M.

21. I hereby certify that I attended the deceased from birth  
Feb 9 1947 to February 9th 1947;  
that I last saw him alive on Feb 9 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death: Prematurity & insufficient development approx 4-5 months gestation - breathed for few hrs  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Q of autopsy \_\_\_\_\_

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 0

23. Signature George E. Grant (M. D. or other) MD  
Address Milan Mo Date signed 2/11/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED  
Lancaster Health Officer No. 10  
MAR 11 1947

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 August Schaefer

Licensed Embalmer No. 2667

P. O. Address Umlan, 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.