

Registration District No. _____

Primary Registration District No. **3000**

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:
902 E. McPherson Street 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**
(c) City or town **Kirksville**
(If outside city or town limits, write "RURAL")
(d) Street No. **604 N. Florence**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Sarah Belle Shafer**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Fred Shafer** 6. (c) Age of husband or wife if alive **71** years

7. Birth date of deceased **August 9 1879**
(Month) (Day) (Year)

8. AGE: Years **68** Months **0** Days **1** If less than one day _____ hr. _____ min.

9. Birthplace **Adair Co Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER { 12. Name **James M. Jones**
13. Birthplace **Unknown Tenn.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Jane Jones**
15. Birthplace **Unknown Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Cleo Hayden**

(b) Address **Kirksville, Missouri**

17. (a) **Burial** (b) Date thereof **8/12/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Hills Cmt.**

18. (a) Signature of funeral director **Det Riley**

(b) Address **Kirksville, Missouri**

19. (a) **8-47** (b) **Rate Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **10**
year **1947** hour **9:00** minute _____ P: _____ M.

21. I hereby certify that I attended the deceased from **August 10**
1947 to **August 10** **1947**
that I last saw her alive on **August 9** **1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Terminal pneumonia** Duration _____

Due to **Cerebral embolism (right side)**

Due to **Essential hypertension**

Other conditions **Essential hypertension & Chronic nephritis**
(Include pregnancy within 3 months of death)

Major findings: **MI**
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 **2**

23. Signature **William C. Kelly** (M. D. or other) **D.O.**
Address **Kirksville, Mo.** Date signed **8-14-47**

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

RECEIVED
District Health Officer No. 10
District File Number 8-17-1082
Date Filed - AUG-1-9-1947

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 DEE RILEY
Licensed Embalmer No. 4181
P. O. Address Kirksville, 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.