

FILED OCT 22 1947

Registration District No. 73

Primary Registration District No. 3014

Registrar's No. 66

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Liberty
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
415 Arthur St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Entire life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24

(c) City or town Liberty 2
(If outside city or town limits, write "RURAL")

(d) Street No. 415 Arthur St 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country No

3. (a) PRINT FULL NAME Minnie Dee Shaver

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9
year 1947 hour 11 minute 50 A. M.

4. Sex Female 5. Color or race White

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

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

7. Birth date of deceased Jan. 19, 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan, 1947, to Oct 9, 1947;
that I last saw her alive on Oct 9, 1947;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

78	8	20	hr. _____ min.
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Immediate cause of death:
Pulmonary Thrombosis
Removal Thrombosis

Duration
35.
Indef.

9. Birthplace Clay Co. 2 miles N.W. Liberty
(City, town, or county) (State or foreign country)

Thrombosed Arteriosclerosis

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business Home

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name John S. Thomason

{ 13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

{ 14. Maiden name Sarah Duvall

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

16. (a) Informant Mrs. C.D. Thomason

22. If death was due to external causes, fill in the following:

(b) Address 125 N. Fairview St. Liberty, Mo.

(a) Accident, suicide, or homicide (specify) _____

17. (a) Burial (b) Date thereof Oct. 11, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence _____

(c) Place: burial or cremation Fairview Liberty, Mo.

(c) Where did injury occur? _____ (City or town) (County) (State)

18. (a) Signature of funeral director O.J. Carder Jr.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(b) Address 119 E. Franklin St. Liberty, Mo.

While at work? _____ (Specify type of place) (e) Means of Injury 0

19. (a) Oct. 10, 1947 (b) Minnie Haynes
(Date received local registrar) (Registrar's signature)

23. Signature Clara W. Shaver (M. D. or pathologist)

Address Liberty, Mo. Date signed 10/19/47

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 10-20-47

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 _____

Licensed Embalmer No. 3934

P. O. Address Liberty, 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.