

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 17 1948

Registration District No. 47

Primary Registration District No. 3009

Registrar's No. H8

1. PLACE OF DEATH:
(a) County CALLAWAY
(b) City or town FULTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 mo 17 days
(Specify whether
In this community same
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County BOONE 10
(c) City or town COLUMBIA 2
(If outside city or town limits, write "RURAL.") 4
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM HOLLIS SHEARER
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month FEBR. day SIXTH
year 1948 hour 6 minute 30 A.M.
21. I hereby certify that I attended the deceased from AUGUST 19
1947 to FEBR. 6, 1948
that I last saw him alive on FEBR. 6, 1948
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased FEBR. 14 1900
(Month) (Day) (Year)

Immediate cause of death CEREBRAL LES, MENINGO-VASULAR TYPE
Duration + 3 1/2 y

8. AGE: Years Months Days If less than one day
47 11 22 _____ hr. _____ min.

Due to _____
Due to _____

9. Birthplace BOONE COUNTY MISSOURI
(City, town, or county) (State or foreign country)
10. Usual occupation SHOE WORKER

Other conditions (Include pregnancy within 3 months of death) 30
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER
11. Industry or business _____
12. Name GORDON MARSHALL SHEARER
13. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)
14. Maiden name KENT
15. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)

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 _____

16. (a) Informant MRS. FRANK WYATT
(b) Address 210 PRICE AVE, COLUMBIA, Mo
17. (a) Burial (b) Date thereof Feb. 8, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Columbia, Mo.
18. (a) Signature of funeral director Glen Y. Mason
(b) Address 712 Cant Fulton, Mo.
19. (a) 2-8-48 (b) Joseph Mason
(Date received local registrar) (Registrar's signature)

23. Signature DR. CREMER by [Signature] (M. D. or other)
Address STATE HOSPITAL Date signed 2/16/48

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

8-43
7-39
571823

RECEIVED
District Health Officer No. 9
District File Number
Date Filed 2/13/48

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.....

Theodore Skinner, Jr., Registered Apprentice No. *55*
working under my personal supervision.

Signed *Glen Y. Manpin*

Licensed Embalmer No. *2725*

P. O. Address *Fulton, 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.

No. 2B
-3-45
1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 48

Registration District No. 47 Primary Registration District No. 8008

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Freiberg
(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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Wm H. Shearer

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 div

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

7. Birth date of deceased Feb 1948
(Month) (Day) (Year)

8. AGE: Years 47 Months 11 Days _____ If less than one day _____
hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

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

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb 8 1948 (b) Joie M. Mankoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I first saw him _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

4151