

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9216**

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 27 1948

Registration District No. **pk 4**

Primary Registration District No. **2022**

Registrar's No. **34**

1. PLACE OF DEATH:

(a) County **Johnson**
(b) City or town **Warrensburg**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Warrensburg Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Month 17 Days**
(Specify whether
In this community **57 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson**
(c) City or town **Warrensburg**
(If outside city or town limits, write "RURAL")
(d) Street No. **336 E. Market**
(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 **16**
year **1948** hour **5 5** minute **00** P. M.

21. I hereby certify that I attended the deceased from **2-29-48** to **3-16-48**
that I last saw her alive on **3-16**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Colon**
Duration **?**

Due to _____
Due to _____

Other conditions **Fracture hip**
(Include pregnancy within 3 months of death)
Intrauterine

Major findings:
Of operations _____
Of autopsy **1618**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence **51**
(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? _____
(Specify type of place)While at work? _____ Means of injury **0**

Signature **Phel C. G. G. G.** (M. D. or other) **0**
Address **Warrensburg** Date signed **3-18-48**

3. (a) PRINT FULL NAME **Emma Jane Shaneyfelt**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **June 22 1869**
(Month) (Day) (Year)

8. AGE: Years **78** Months **8** Days **24** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **Nathan Shaneyfelt**

13. Birthplace **Uniontown Pa.**
(City, town, or county) (State or foreign country)

14. Maiden name **Lizabeth Logan**

15. Birthplace **Warren County Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Frank Anderson**

(b) Address **318 E Market Warrensburg**

17. (a) **Burial** (b) Date thereof **3-18-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Hill**

18. (a) Signature of funeral director **Sweeney-Phillips**

(b) Address **Warrensburg Mo.**

19. (a) **May 19, 1948** (b) **Sarannek**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

ADDITIONAL INFORMATION REQUESTED

PHYSICIAN Underline the cause of death which should be certified statistically

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.....

Ed Jack Phillips Registered Apprentice No. *14*
working under my personal supervision.

Signed *RJ Phillips*

Licensed Embalmer No. *2320*

P. O. Address *Warrensburg*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 34

Registration District No. 39 Primary Registration District No. 5082

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

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Warrensburg
(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 _____ years, months or days)
3. (a) PRINT FULL NAME Emma J. Sanceyfelt
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 2 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased June 22 (Month) (Day) (Year)

8. AGE: 78 Years 8 Months no Days If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 March Day 16 Year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; 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) Broken hip

(b) Date of occurrence 1-30-48

(c) Where did injury occur? Warrensburg Johnson mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Home While at work? _____ (Specify type of place) (e) Means of injury fell

23. Signature R Lee Cooper (M. D. or other) _____

Address Warrensburg Date signed 4/1/48

SUPPLEMENTAL

S-98-16