

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED APR 7 1949

State File No. **9142**

BIRTH NO. _____		REG. DIST. NO. 195		PRIMARY REG. DIST. NO. 5706		Registrar's No. 23	
1. PLACE OF DEATH a. COUNTY McDonald				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY McDonald			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Anderson twp.		c. LENGTH OF STAY (In this place) 8 YRS.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Anderson twp.			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1 Mile South of Goodman				d. STREET ADDRESS (If rural, give location) 1 Mile South of Goodman			
3. NAME OF DECEASED (Type or Print) a. (First) LEONARD			b. (Middle) WILLIAM		c. (Last) SHEARWOOD		4. DATE OF DEATH (Month) (Day) (Year) 3 21 49
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Nov. 5-1940		9. AGE (In years last birthday) 8	IF UNDER 1 YEAR Months 4 Days 16	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School child		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) McDonald Co. Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Chester S. Shearwood		13b. MOTHER'S MAIDEN NAME Helen J. Robinson		14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Chester S. Shearwood		ADDRESS. Goodman Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* HOWTE TOXIC MYOCARDITIS. ANTECEDENT CAUSES DUE TO (b) DIPHTHERIA. HAD BEEN ILL 7 or 8 DAYS BEFORE CONSULTING PHYSICIAN DUE TO (c) before consulting physician II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 055*				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 3-11-1949 to 3-21-1949 , that I last saw the deceased alive on 3-20-1949 , and that death occurred at 9:30 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Paul C. Davis M.D.				23b. ADDRESS Neosho Mo		23c. DATE SIGNED 3/22/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/23/1949	24c. NAME OF CEMETERY OR CREMATORY Beaver Springs Cem		24d. LOCATION (City, town, or county) (State) Anderson, Mo		
DATE REC'D BY LOCAL REG. 3-24-49		REGISTRAR'S SIGNATURE Mayme Humphrey		423 25. FUNERAL DIRECTOR'S SIGNATURE John B. Popineau		ADDRESS Goodman Mo.	

(Licensed Embalmer's Placement on Reverse Side)

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

6000

RECEIVED
District Health Officer
District File Number 449
Date Filed 4-6-4

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed John B. Papineau
Licensed Embalmer No. 4446

Signed
Student Embalmer

P. O. Address Goodman, Me

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.