

FILED AUG 31 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 27209

49
23

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar's No. 356

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution) a. STATE MISSOURI b. COUNTY JASPER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin 49	
d. FULL NAME OF HOSPITAL OR INSTITUTION Friends Hospital		d. STREET ADDRESS (If rural, give location) 2317 Va. ave 5	
3. NAME OF DECEASED (Type or Print) a. (First) DR. WILLIAM c. (Middle) C. e. (Last) SHAW.			4. DATE OF DEATH (Month) (Day) (Year) AUG 10 1949
5. SEX M - F W	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-19-1882
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist	11. BIRTHPLACE (State or foreign country) Quincy Ill. 1
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME unknown	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Mrs. Cora Shaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Vascular Heart Dis 2 yrs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Intra thoracic neoplasm of undetermined type	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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 Aug 5, 1949, to Aug 10, 1949, that I last saw the deceased alive on Aug 10, 1949, and that death occurred at 7:00 p.m., from the causes and on the date stated above.			
23a. SIGNATURE E. H. Hamilton M.D. Joplin Mo		23b. ADDRESS	
23c. DATE SIGNED 8-11-49.			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 8/12/49	
24c. NAME OF CEMETERY OR CREMATORY Mt Hope Cem		24d. LOCATION (City, town, or county) (State) Webb City Mo	
DATE REC'D BY LOCAL REG. 8-11-49		REGISTRAR'S SIGNATURE: J. B. James	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Funeral Home		L. K. Hurlbut Joplin	

Hamilton
RECEIVED 8-29-49

Jasper County Health Office

County File Number 49-8-642

Date Filed 8-29-49

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 _____

Kat G. Hale

Student Embalmer No. 317

working under my personal supervision.

Kat G. Hale

Student
Student Embalmer

Signed _____

Ray K. Hurlbut

Licensed Embalmer No. 959

P. O. Address Joseph New

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.