

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FEB 25 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **64** PRIMARY REG. DIST. NO. **5245** Registrar's No. **10**

1. PLACE OF DEATH a. COUNTY <b>Chariton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Chariton</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Keytesville Twp, Rural</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Keytesville, Twp. Rural</b>	
c. LENGTH OF STAY (In this place) <input checked="" type="checkbox"/>		d. STREET ADDRESS (If rural, give location) <b>Northwest of Keytesville</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Northwest of Keytesville</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Lorenzo</b>	b. (Middle) <b>William</b>	c. (Last) <b>Shands</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 15, 1952</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Apr. 18, 1886</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>27</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Optometrist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Fit glasses</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Keytesville, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>Robert R. Shands</b>	13b. MOTHER'S MAIDEN NAME <b>Katie E. Mutter</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Miss Edith Price</b>	ADDRESS <b>Keytesville, Mo</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4201</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (Min.)	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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **9:30A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>H. D. Garnett</b>	(Degree or title) <b>3</b>	23b. ADDRESS <b>Keytesville Mo.</b>	23c. DATE SIGNED <b>2-17-1952</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>2/17/52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt Pleasant</b>	24d. LOCATION (City, town, or county) (State) <b>Near Keytesville Mo</b>
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DATE REC'D BY LOCAL REG. <b>2/18/52</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>	ADDRESS <b>Marion Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 \_\_\_\_\_ X

Student Embalmer No. \_\_\_\_\_ X

working under my personal supervision.

Student \_\_\_\_\_ X  
Student Embalmer

Signed George W. Davall

Licensed Embalmer No. 4799

P. O. Address Marble, MD

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.