

FILED APR 19 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13121

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1536

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL, and give town or town) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL, and give township) <u>La Plata MO</u>	
c. LENGTH OF STAY (in this place) <u>6 mo</u>		d. STREET ADDRESS (If rural, give location) <u>0610</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Neurological Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jacob</u>		b. (Middle) <u>D.</u>	c. (Last) <u>Shaffer</u>
4. DATE OF DEATH (Month) (Day) (Year) <u>April 2 1952</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 12, 1892</u>
9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>Jacob Shaffer</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>EVA SHAFER</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONP</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>W W Shaffer 7138 Highland</u>
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Accident</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u>  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 <u>None</u>		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) _____		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 <u>March 16, 1952</u> , to <u>April 2, 1952</u> , that I last saw the deceased alive on <u>April 2, 1952</u> , and that death occurred at <u>7:55 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Albert Preston, Jr.</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>4635 Wyandotte St. K.C.Mo.</u>	23c. DATE SIGNED <u>April 2, 1952</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4/13/52</u>	24c. NAME OF CEMETERY OR CREMATORY _____
24d. LOCATION (City, town, or county) (State) <u>La Plata MO</u>			
DATE REC'D BY LOCAL REG. <u>4-3-52</u>		REGISTRAR'S SIGNATURE <u>Sheldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Stine-McClure K.C.Mo.</u>

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.....

.....  
working under my personal supervision.

..... Student Embalmer No.....

Signed..... *F. S. Walton* .....

Signed.....  
Student Embalmer

Licensed Embalmer No. *2744* .....

P. O. Address *K C 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.