

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34812**

S. No. 300  
v. 10.48

FILED NOV 3 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **139** PRIMARY REG. DIST. NO. **5536** Registrar's No. **72**

0442

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

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Holt</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Holt</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Lewis Twp.</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Lewis Twp.</b>                                    |  |
| c. LENGTH OF STAY (In this place) <b>20 yrs.</b>   |  | d. STREET ADDRESS (If rural, give location) <b>2 Mi. S. of Oregon, Mo.</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2 Mi. S. of Oregon, Mo.</b>                               |  |   |  |

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Roy</b> b. (Middle) <b>Edward</b> c. (Last) <b>Shaffer</b> |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Oct. 28, 1952</b> |   |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>                    |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>   |  |
| 8. DATE OF BIRTH <b>Mar. 27, 1884</b>   |  | 9. AGE (In years last birthday) <b>68</b>        |   | 10. UNDER 1 YEAR (Month) (Day) (Year) <b>68</b>                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>       |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b> |   | 11. BIRTHPLACE (City and State or Foreign Country) <b>Gravity, Iowa</b> |  |
|   |  |  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                              |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 13a. FATHER'S NAME <b>David Shaffer</b>   |  | 13b. MOTHER'S MAIDEN NAME <b>Sarah Gralley</b> |  | 14. NAME OF HUSBAND OR WIFE <b>Maude Ethel Shaffer</b>                             |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b> |  | 16. SOCIAL SECURITY NO. <b>None</b>            |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Maude E. Shaffer Oregon, Mo.</b> |  |

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CORONARY OCCLUSION</b>   |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b> |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |   |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  |  |   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 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) (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 **No**, 19\_\_\_, to \_\_\_ 19\_\_\_, that I last saw the deceased alive on **No**, 19\_\_\_, and that death occurred at **9 a. m.**, from the causes and on the date stated above.

|  |  |                               |  |                                  |  |
|--|--|-------------------------------|--|----------------------------------|--|
| 23a. SIGNATURE (Degree or title) <b>Dr. H. E. Carlin</b> |  | 23b. ADDRESS <b>Oregon Mo</b> |  | 23c. DATE SIGNED <b>10-29-52</b> |  |
|--|--|-------------------------------|--|----------------------------------|--|

|   |  |                           |  |   |  |   |  |
|---|--|---------------------------|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> |  | 24b. DATE <b>10/30/52</b> |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope Cemetery</b> |  | 24d. LOCATION (City, town, or county) (State) <b>Mound City, Missouri</b> |  |
|---|--|---------------------------|--|---|--|---|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. <b>10/29/1952</b> |  | REGISTRAR'S SIGNATURE <b>James D. Crawford</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. Crawford</b> |  |
|--|--|--|--|--|--|

**STATEMENT BY LICENSED EMBALMER**

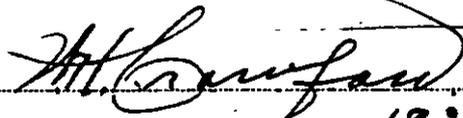
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed



Licensed Embalmer No. 1824

P. O. Address Mound City, Mo.

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.