No. 300
10.48

6000
0

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

FILED JUN 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15295

BIRTH NO. _____ REG. DIST. NO. 72 PRIMARY REG. DIST. NO. 4134 Registrar's No. 41

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Smithville
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Community Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Davies
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hidder
d. STREET ADDRESS (If rural, give location): R.F.D. I

3. NAME OF DECEASED (Type or Print): a. (First) Charles b. (Middle) Edward c. (Last) Shaw

4. DATE OF DEATH: (Month) May (Day) 27 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 15 1878
9. AGE (In years last birthday): 76 IF UNDER 1 YEAR: Months 2 Days 12 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: X X
11. BIRTHPLACE (City and State or Foreign Country): Arkansas City Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Dennis Shaw
13b. MOTHER'S MAIDEN NAME: Minnerva Beck
14. NAME OF HUSBAND OR WIFE: Georgia Lee Shaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): X X
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Georgia Shaw ADDRESS: Hidder 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Benign Hypertrophy Prostate — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) Chronic Pyelonephritis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Myocardial Degeneration — 6 10 X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Benign Hypertrophy Prostate
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 30, 1954, to May 27, 1954, that I last saw the deceased alive on May 27, 1954, and that death occurred at 7 p m., from the causes and on the date stated above.

23a. SIGNATURE: C. E. Belman (Degree or title) MD
23b. ADDRESS: Smithville Mo
23c. DATE SIGNED: 5/28/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5/30/54
24c. NAME OF CEMETERY OR CREMATORY: Green Lawn
24d. LOCATION (City, town, or county) (State): Plattsburg, Mo.

DATE REC'D BY LOCAL REG.: 5-30-54
REGISTRAR'S SIGNATURE: Marguerite Hudgens
25. FUNERAL DIRECTOR'S SIGNATURE: D. D. Lyon ADDRESS: Plattsburg Mo

(Licensed Embalmer's Statement on Reverse Side)

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 Darrell D. Lyon

Licensed Embalmer No. 3640

P. O. Address Plattsburg, 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.