

Health,
& Welfare
S. Public
th Service

FILED JUN 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 0 1 7 7 9 1
STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 57

S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY McDonald	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		c. CITY OR TOWN Goodman	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State Sanatorium		Length of stay in lb 68 days	
d. STREET ADDRESS		(If outside, give location) 0	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mamie Middle Frances Last Shaver			4. DATE OF DEATH Month May Day 23 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1890
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME William Madison		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Robert Cloyd Shaver
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address San. records, Mo. State San., Mt. Vernon, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism pulmonary infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) & Thrombophlebitis, left leg DUE TO (c) 463xA			INTERVAL BETWEEN ONSET AND DEATH approx. 3 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchiectasis, left lower lobe of lung, Pulmonary tuberculosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from March 16, 1957 to May 23, 1957 and last saw her alive on May 23, 1957 Death occurred at 10:55 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE C. A. Brasher M.D. (Degree or title)		22b. ADDRESS Mt. Vernon, Mo.	
22c. DATE SIGNED 5-24-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-24-57	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Goodman Mo	
24. FUNERAL DIRECTOR Way L. Fousett ADDRESS Mt. Vernon Mo		25. DATE RECD. BY LOCAL REG. 5-27-57	
26. REGISTRAR'S SIGNATURE Carroll Handwerker			

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
Signature of Student Embalmer

Signed *Max L. Fournier*

Licensed Embalmer No. *252*

P. O. Address *W. L. ...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.