

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021395
State File No.

FILED JUL 14 1958

BIRTH NO. REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 3018 Registrar's No. 64

1. PLACE OF DEATH a. COUNTY Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, write RURAL and give township) Salem		c. CITY OR TOWN Salem	
c. LENGTH OF STAY (in this place) 10 yrs		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Jail		e. STREET ADDRESS (If rural, give location) West 3rd	

3. NAME OF DECEASED (Type or Print)	a. (First) Oman	b. (Middle) Adolph	c. (Last) Shaw	4. DATE OF DEATH (Month) (Day) (Year) July 3 1958
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb 21 1908	9. AGE (In years last birthday) Months Days Hours Mins. 50
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labreer	10b. KIND OF BUSINESS OR INDUSTRY general	11. BIRTHPLACE (City and State or Foreign Country) Reynolds Co Mo	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME John Shaw	13b. MOTHER'S MAIDEN NAME Emma Chapman	14. NAME OF HUSBAND OR WIFE X
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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) No	16. SOCIAL SECURITY NO. X 488 18 2896	17. INFORMANT'S SIGNATURE OR NAME Mrs Dessie Woolf	ADDRESS Salem Mo
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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) Severe Beating of head & face area.		
	ANTECEDENT CAUSES. Morbidity 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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Homicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Salem Mo
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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?
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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 **4:30 P.M.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Walter B. Powell, D.C. Coroner	23b. ADDRESS Salem Mo.	23c. DATE SIGNED 7-6-58
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24a. BURIAL, CREMATION, or MOVIAL (Specify) burial	24b. DATE 7-6-58	24c. NAME OF CEMETERY OR CREMATORY Greeley Cem	24d. LOCATION (City, town, or county) (State) Greeley Mo
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DATE REC'D BY LOCAL REG. 7/6/58	REGISTRAR'S SIGNATURE M. M. [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS [Address]
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

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.....
Carl H. Spitzer

Licensed Embalmer No.....
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P. O. Address.....
Salem

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.