

Health,
& Welfare
Public
Service
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025211
STATE FILE NUMBER

FILED AUG 11 1958 Registration District No. 128 Primary Registration District No. 200 Registrar's No. 776

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Inside Limits Year <u>1958</u> No <input type="checkbox"/>		c. CITY OR TOWN <u>Springfield</u> 0396 Inside Limits Year <u>1958</u> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u> Length of stay in lb <u>Life</u>		d. STREET ADDRESS (If outside, give location) <u>2443 W. Bennett</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Elizabeth Shaw</u>			4. DATE OF DEATH Month Day Year <u>August 5, 1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1915</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Springfield, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Charles Martin Corn</u>	13b. MOTHER'S MAIDEN NAME <u>Ethel Brockus</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas Edward Shaw</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Thomas E. Shaw - Springfield, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>metastatic carcinoma</u> DUE TO (c) <u>Squamous cell carcinoma of the cervix</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>171X</u>		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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
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21. I attended the deceased from <u>5-15-57</u> to <u>8-5-58</u> and last saw ^{her} _{him} alive on <u>8-5-58</u> Death occurred at <u>6-15-57 pm. no.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>M. Bonbrake MD</u>	22b. ADDRESS <u>Prof. Billy Springfield Mo</u>	22c. DATE SIGNED <u>8-8-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-8-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey - Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-8-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie B. Melton</u>
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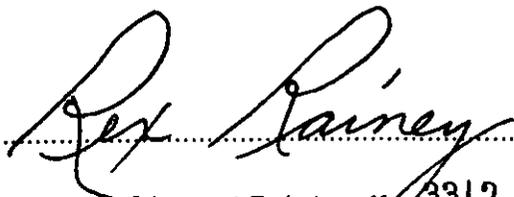
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 3312

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