

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013121

STATE FILE NUMBER

APR 28 1959 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 45

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u> 10461	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1118 East</u>		d. STREET ADDRESS <u>1118 East</u>	
3. NAME OF DECEASED (Type or print) <u>Christian Bailey Shaw</u>		4. DATE OF DEATH <u>4-8-1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)
<u>Retired Teacher</u>			<u>Russell Ind. Mo</u>
13a. FATHER'S NAME <u>Geo C. Shaw</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Fritz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
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>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u>		<u>10 years</u>	
DUE TO (c) <u>Senility</u>		<u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.) <u>332 X</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT WORK <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	
21. I attended the deceased from <u>3/2/59</u> to <u>4/8/59</u> and last saw <sup>her</sup> him alive on <u>4/8/59</u> Death occurred at <u>7:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M. L. Fowler</u>		22b. ADDRESS <u>West Plains Mo</u>	
22c. DATE SIGNED <u>4/20/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>4-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>
24. FUNERAL DIRECTOR <u>Robertson's West Plains Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-24-59</u>	26. REGISTRAR'S SIGNATURE <u>Leatrice Cook</u>

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 *D. Roberts* .....

Licensed Embalmer No. *2637* .....  
P. O. Address *West Hill* .....

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.