

Registration District No. 139 Primary Registration District No. \_\_\_\_\_ Registrar's No. 48

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>HOLT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BENTON TWP.</u>		Length of stay in 1b <u>25 YRS</u>		c. CITY OR TOWN <u>MOUND CITY</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION <u>3 mi S. MOUND CITY</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3 miles South</u>			
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>SCOTT</u> Last <u>SHAFFER</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>25</u> Year <u>1959</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/17/1887</u>		
9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>IRROQUOIS, S.D.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>DAVID HIRAM SHAFFER</u>			13b. MOTHER'S MAIDEN NAME <u>SARAH GREELEY</u>			14. NAME OF HUSBAND OR WIFE _____		
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>UNKNOWN</u>		17. INFORMANT <u>ALBERT RICHARDSON - Forest City, Mo.</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>							<u>3 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Coronary Arteriosclerosis</u>				<u>at least 5 yrs.</u>	
			DUE TO (c) <u>Generalized Arteriosclerosis</u>				<u>5+ years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m. Month, Day, Year _____								
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>July '55</u> to <u>Sept. 25, 1959</u> and last saw him alive on <u>Sept 25, 1959</u> Death occurred at <u>7 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>James Humphrey M.D.</u> (Degree or title)				22b. ADDRESS <u>Mound City, Mo.</u>			22c. DATE SIGNED <u>9/26/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9/27/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE</u>		23d. LOCATION (City, town, or county) (State) <u>MOUND CITY, MO.</u>			
24. FUNERAL DIRECTOR <u>James Crawford Mound City, Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>9/26/1959</u>		26. REGISTRAR'S SIGNATURE <u>James Crawford</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James Crawford

Licensed Embalmer No. 4796

P. O. Address Mound City

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.