

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004868

FILED VS JAN 26 1960

360

6225

8

STATE FILE NUMBER

NDED

Registration District No. \_\_\_\_\_ Primary Registration District No. 6225 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY <b>VERNON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wright</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Twp</b>	Length of stay in 1b <b>2 YRS - 10 MO</b>	c. CITY OR TOWN <b>Manstield</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Nevada State Hospital, Nevada</b>		d. STREET ADDRESS (If outside, give location) <b>None given</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Harrison</b> Middle <b>Shaw</b> Last			4. DATE OF DEATH Month <b>Jan</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 31, 1894</b>	9. AGE (last birthday) <b>68 YRS</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>16</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Tennessee</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		

13a. FATHER'S NAME <b>William Shaw</b>	13b. MOTHER'S MAIDEN NAME <b>Vernia Hattfield Hattfield</b>	14. NAME OF HUSBAND OR WIFE <b>Ellen Shaw</b>
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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) <input checked="" type="checkbox"/> Yes <b>WW I</b>	16. SOCIAL SECURITY NO. <b>500-01-3642</b>	17. INFORMANT <b>Records Nevada State Hosp. Nevada, Mo</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Cerebral Hemorrhage</b>	<b>several minutes</b>
CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>generalized Arterio-Sclerosis</b>	<b>several years</b>
	DUE TO (c) <b>Senile Psychosis</b>	<b>several years</b>
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"/> <b>None</b>	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 **March 5, 1957** to **Jan 10, 1960** and last saw <sup>her</sup>him alive on **Jan 15, 1960**  
Death occurred at **6.15** **a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Leslie H Wright M.D.</b>	22b. ADDRESS <b>Nevada State Hospital</b>	22c. DATE SIGNED <b>Jan 15, 1960</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JAN. 15, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Number 5</b>
23d. LOCATION (City, town, or county) <b>Wright County Mo.</b>		

24. FUNERAL DIRECTOR <b>Max J Miller</b>	ADDRESS <b>Manstield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1-18-1960</b>	26. REGISTRAR'S SIGNATURE <b>Ormal E Jerrys</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed Max L Miller

Licensed Embalmer No. 4720

P. O. Address Manfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.