

**RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS APR 27 1960**

**60-016462**  
 STATE FILE NUMBER

Registration District No. 294 Primary Registration District No. 2056 Registrar's No. 108

1. PLACE OF DEATH a. COUNTY <b>Randolph</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Moberly</b>		Length of stay in 1b <b>10 days</b>	c. CITY OR TOWN <b>Hannibal, Missouri</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>Wabash Employes' Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2801 St. Marys Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES ALBERT SHAW</b>			4. DATE OF DEATH Month Day Year <b>April 17, 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/5/ 1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Switchman - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wabash RR Company</b>	11. BIRTHPLACE (City and state or country) <b>Unk.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		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)		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>O'Donnell Funeral Home Hannibal, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infirmities</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		
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"/> N- <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 Month, Day, Year 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 <b>April 6, 1960</b> to <b>Apr. 17, 1960</b> and last saw him alive on <b>April 16, 1960</b> Death occurred at <b>3:40 A. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>R. K. McMurtry, M.D., Surgeon in Charge</b>			22b. ADDRESS <b>Wabash Employes' Hospital Moberly, Missouri</b>		22c. DATE SIGNED <b>4/18/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-17-1960</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Hannibal Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>O'Donnell Funeral Home Hannibal</b>		25. DATE RECD. BY LOCAL REG. <b>4-17-60</b>	26. REGISTRAR'S SIGNATURE <b>W. H. Lowe</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAY 4 1964

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 John A. Greer

Licensed Embalmer No. 3815

P. O. Address \_\_\_\_\_

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.