

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041156

FILED VS NOV 28 1960 042 Primary Registration District No. 1000 Registrar's No. 1206

STATE FILE NUMBER

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY BUCHANAN | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ANDREW | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. JOSEPH | | Length of stay in 1b 5 days | | c. CITY OR TOWN ROSENDALE | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) (If outside, give location) | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last SARAH ANN SHAIFFER | | | | 4. DATE OF DEATH Month Day Year November 18, 1960 | | | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 2-22-85 | 9. AGE (last birthday) 75 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (City and state or country) Indiana | | 12. CITIZEN OF WHAT COUNTRY U S A | | |
| 13a. FATHER'S NAME Thomas Handy | | | 13b. MOTHER'S MAIDEN NAME Mary Ann Morgan | | | 14. NAME OF HUSBAND OR WIFE William Shaiffer | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. - - - | | 17. INFORMANT Address William Shaiffer, Rosendale, Mo. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 days | | |
| 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) Arterio-sclerotic heart disease | | | | | 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 11-10-60 to 11-18-60 and last saw her her alive on 11-18-60 Death occurred at 8:55 AM on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE <i>Conrad Long M.D.</i> (Degree or title) | | | | 22b. ADDRESS Savannah, Missouri | | | | 22c. DATE SIGNED 11-18-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 11-18-60 | 23c. NAME OF CEMETERY OR CREMATORY Savannah Cemetery | | 23d. LOCATION (City, town, or county) (State) Savannah, Missouri | | | | |
| 24. FUNERAL DIRECTOR BREIT & HAWKINS SAVANNAH | | | 25. DATE RECD. BY LOCAL REG. Nov. 21, 1960 | | 26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Gardell</i> | | | | |

DOCUMENT

F.C. Long, M.D. 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

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.