DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28902

SEP 23 1946

Registration District No. 93-2

Primary Registration District No. 3617

Registrar's No.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Falcon (If outside city or town limits, write "RURAL" and name of township) Mo Blanchard
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede
(c) City or town Falcon Mo Blanchard (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William Shaffer
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Sarah Shaffer
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 27 (Day) 1858 (Year)

8. AGE: Years 87 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Pennsylvania (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Henry Shaffer
13. Birthplace Pennsylvania (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Rebecca Rafferty
15. Birthplace Pennsylvania (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Sarah Shaffer
(b) Address Falcon Mo Blanchard
17. (a) Lonesome Hill (Burial, cremation, or removal) (b) Date thereof Aug 10 46 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director E M Stewart
(b) Address Lebanon Mo
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 5
year 1946 hour 3.30 minute P M.
21. I hereby certify that I attended the deceased from Viewed the Body
19..., to 19...;
that I last saw h... alive on 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Indigestion	0
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature James D Stanton Coroner (Coroner or other)
Address Date signed 8-8-46

(Licensed Embalmer's Statement on Reverse Side)

115 C

RECEIVED
District Health Officer No. 7,
District File Number 9-40-1299
Date Filed 9-11-40

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~~ E N Stew

....., Registered Apprentice No.....

working under my personal supervision.

Signed E N Stewart

Licensed Embalmer No. 1885

P. O. Address Lebanon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28902

Registration District No. 9512 Primary Registration District No. 5617 Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Franklin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William Shaffer
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years.

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 81 Months 11 Days 11 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Indigestion	
Due to Duodenal ulcer	
Due to 1208	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature J O Stanton (Coroner or other)
Address Date signed

SUPPLEMENTARY

lo. 2B
-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28902

Registration District No. 95-2

Primary Registration District No. 0617

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

(b) ~~City or town~~ Franklin T. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No. 4
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William Shaffer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
81	11	11	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Oct. 18, 1940 (b) Mrs. Vida Lambeth
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature James D Stanton (M. D. or other)

Address Lebanon Mo. Date signed

SUPPLEMENTARY