

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Ship
14931
Do not use this space.

DEC'D MAY 11 1939

1. PLACE OF DEATH
(a) County GREENE Registration District No. 318
(b) Township S. Campbell Primary Registration District No. 5440 Registered No. 350
(c) City SPRINGFIELD (d) Street No. MEDICAL CENTER FOR FEDERAL PRISONERS St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 0 yrs. 8 mos. 21 ds. (f) How long in U. S., if of foreign birth? - yrs. - mos. - ds.

2. PRINT FULL NAME SHAFFER, William Baxter
(a) Residence, No. Parsons, West Va. St. Parsons, W. Va.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lucinda Shaffer
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 5, 1866
7. AGE YEARS 73 MONTHS 0 DAYS 21 If LESS than 1 day,hrs. ormin.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. D. K.
10. Date deceased last worked at this occupation (month and year) 11. K. 11. Total time (years) spent in this occupation.
12. BIRTHPLACE (CITY OR TOWN) Barber County / (STATE OR COUNTRY) West Virginia /
13. NAME Henry Shaffer /
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia /
15. MAIDEN NAME Nancy (Pitcher) Shaffer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia
17. INFORMANT Hospital records (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL PLACE Parsons, W. Va. DATE 4-27-39 19.
19. FUNERAL DIRECTOR (NAME) A. Lohmeyer Funeral Home (ADDRESS) Springfield, Mo.
20. FILED 4-26 1939 Chas. A. George Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 26, 1939 19
22. I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1938, 19..... to Apr. 26, 1939, 19.....
I last saw him alive on Apr. 26, 1939, 19..... Death is said to have occurred on the date stated above, at 9:15 P. M.
The principal cause of death and related causes of importance were as follows:
Hemorrhage, cerebral Date of onset 4-21-39
gpc
Other contributory causes of importance:
Cardiac disease, auricular fibrillation DK
Chronic myocarditis DK
Arteriosclerosis DK
Hypertension DK
Name of operation None Date of.....
What test confirmed diagnosis? Clinical Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....
24. Was disease of injury in any way related to occupation of deceased? No
If so, specify Shaffer
(Signed) J. L. Wilson, P. A. Surgeon, M. D.
(Address) U. S. Public Health Service, ICFP, Springfield, Mo.

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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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

X