

STANDARD CERTIFICATE OF DEATH

State File No. 39690

Registration District No. 328

Primary Registration District No. 3017

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Trundy  
 (b) City or town Trenton Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Hobson M<sup>c</sup>Farland  
none tractor Co. in Trenton  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community Lived in Edinburgh Mo 26 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Trundy  
 (c) City or town Edinburgh, Mo.  
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30  
 year 1939 hour 9 minute A M.

21. I hereby certify that I attended the deceased from Warmed body as coroner  
 that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death head crushed by machinery while working  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy None held  
Cause of death evident

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) accident  
 (b) Date of occurrence Nov 30 1939  
 (c) Where did injury occur at RSPRY Co  
 (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Hobson M<sup>c</sup>Farland tractor Co  
 (Specify type of place)  
 While at work \_\_\_\_\_ (Means of injury) stroke  
 on \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address Trenton Mo Date signed 12-2-39

3. (a) PRINT FULL NAME HOWARD JEWETT SHAW

3. (b) If veteran, name war none 3. (c) Social Security No. 486-12-7156

4. Sex m. 5. Color or race w. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Pauline 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased May 12 1903  
 (Month) (Day) (Year)

8. AGE: Years 36 Months 6 Days 18  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Employee of Hobson M<sup>c</sup>Farland tractor

11. Industry or business Tractor Co.

12. Name Zeliey Shaw

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

14. Maiden name Martha Johnson

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

16. (a) Informant's own signature Pauline Shaw

(b) Address Edinburgh, Mo.

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

(c) Place: burial or cremation Shelburn Cemetery

18. (a) Signature of funeral director Hemley Junton R. Hemley

(b) Address 813 Euster Trenton, Mo.

19. (a) 11-30-1939 (b) Howard Jewett Shaw  
 (Date received local registrar) (Registrar's signature)

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

2058  
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STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH SERVICES

**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.

*Clifford Abney*

Signed.....

*Clifford Abney*

Licensed Embalmer No.....

*3482*

P. O. Address.....

*Brenton MO*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **39690**

Registration District No. **328**

Primary Registration District No. **3017**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Grundy**  
 (b) City or town \_\_\_\_\_  
 (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 \_\_\_\_\_)  
 In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 years, months or days

3. (a) PRINT FULL NAME **Howard Jewett Shaw**

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 **36** Months **6** Days **18** If less than one year \_\_\_\_\_ 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)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **30** year **1939** hour **7:45 AM** minute \_\_\_\_\_ M.

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

Immediate cause of death **Head crushed by machinery with which he was working** Duration \_\_\_\_\_

Due to **throwing a tool**  
**order on R.R. yard**  
**due to car**  
**it was causing the switch to drop.**  
 Other conditions **Other pituitary tumor**  
 (Include pregnancy within 3 months of death)

Major findings: **Head causing his death** PHYSICIAN \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy **None Held**  
**Cause of death evident** 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 **J. G. Fair** \_\_\_\_\_ (M. D. or other)  
 Address **Wentworth** \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

