

S. No. 2
-11-10-39
5-10-1940
P. 1

JAN 21 1941
Registration District No. **604**

Primary Registration District No. **4358**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town New Madrid
(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 _____ years, months or days

3. (a) PRINT FULL NAME (unnamed) Shaw

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced L

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

7. Birth date of deceased Dec 5 1940
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Clopha Shaw

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

14. Maiden name Grace Carley

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

16. (a) Informant Clopha Shaw

(b) Address New Madrid MO

17. (a) Burial (b) Date thereof Dec 14 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hardell

18. (a) Signature of funeral director L. A. Richards

(b) Address New Madrid

19. (a) 12-20-40 (b) Wm O'Bannon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County New Madrid

(c) City or town New Madrid
(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 Dec day 13
year 1940 hour _____ minute 9:15 P. 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 Undernourished - exposure

Due no medical attention, only from record

Due to _____

Other conditions (Include pregnancy within 3 months of death) 158

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? 523

While at work? _____ (Specify type of place) (e) Means of injury coaster

23. Signature L. A. Richards (M. D. or other) _____

Address New Madrid Date signed _____

RECEIVED

District Health Officer No. 2

District File Number 141-58

Date Filed 1/10/41

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.