

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County... Jackson

(b) City or town... Kansas City
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 4 Days
(Specify whether years, months or days)

In this community 38 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 18

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 2804 Chelsea
(If rural, give location)

(e) If foreign born, how long in U. S. A. - 0 years.

3. (a) PRINT FULL NAME Mrs. Clara Belle Shafer

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Mr. William H. Shafer

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

7. Birth date of deceased July 2 1862
(Month) (Day) (Year)

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

78 10 2 hr. min.

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

10. Usual occupation At Home

11. Industry or business -

MOTHER FATHER

12. Name Jacob M. Turneure

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

14. Maiden name Sarah E. LaRue

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

16. (a) Informant Mr. Oscar Shafer

(b) Address 3033 Kensington Avenue

17. (a) Burial (b) Date thereof May 6, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of cremation Mt. Washington Cem.

18. (a) Signature of funeral director O. N. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) May 5 1941 (b) M. M. Brown
(Date reported local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th
year 1941 hour 5 minute 20 A. M.

21. I hereby certify that I attended the deceased from 4/30/41
19 to 5/7/41 1941

that I last saw h. alive on 19
and that death occurred on the date and hour stated above.

Immediate cause of death
Bronchial Pneumonia 3 days

Due to Cerebral Hemorrhage

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 O. N. Russell (M. D. or other) O
Address 30711. a. Judson Ave Date signed 5/12/41

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

3.5.30
2011 U. S. ...

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address D.C. Mo.

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

If this body is not embalmed, fact should be so stated above.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 171-3-67

BIRTH NO. _____ REG. DIST. NO. 399 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1785

1. PLACE OF DEATH ¹ a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN <u>Kansas City</u>		c. CITY OR TOWN _____	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) _____		STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wesley Hoop</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Clara</u> b. (Middle) <u>Belle</u> c. (Last) <u>Shaper</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5-4-41</u>		
5. SEX <u>1</u>	6. COLOR OR RACE _____	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____	8. DATE OF BIRTH _____	9. AGE, (In years last birthday) <u>178</u>	IF UNDER 1 YEAR Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Birthdate was correct</u>	
13a. FATHER'S NAME _____		13b. MOTHER'S MARDEN NAME _____		14. NAME OF HUSBAND OR WIFE <u>Wrong age figured.</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____	
---	-------------------------------	---	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ^(a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____			

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) _____	23b. ADDRESS _____	23c. DATE SIGNED _____
--	--------------------	------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE _____	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) _____ (State) _____
---	-----------------	--	---

DATE REC'D BY LOCAL REG. <u>5-5-41</u>	REGISTRAR'S SIGNATURE <u>M. M. Crowe</u>	25. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____
--	--	--

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

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.....

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.