

FILLED NOV 17 1941

Registration District No. \_\_\_\_\_

Primary Registration District No. 1

Registrar's No. 290

**1. PLACE OF DEATH:**  
 (a) County Adair  
 (b) City or town Kirkville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1223 North Elston  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 Yrs  
(Specify whether years, months or days)  
 In this community \_\_\_\_\_

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Adair  
 (c) City or town Kirkville Missouri  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1223 North Elston St.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** James William Shriver  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Oct day 13  
 year 1941 hour 9 minute 30 M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Dora Helen (Scher) Shriver 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased (Month) 12 (Day) 17 (Year) 1855

21. I hereby certify that I attended the deceased from 1940 to Oct 13 1941  
 that I last saw him alive on Oct 13 1941  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>9</u>	<u>27</u>	hr. _____ min. _____

Immediate cause of death Peritonitis  
 Due to Causes of Peritonitis  
 Due to \_\_\_\_\_

9. Birthplace Morgan Town / Ohio  
(City, town, or county) (State or foreign country)

Other conditions 1  
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer  
 11. Industry or business Farm

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy etc

**MOTHER FATHER**  
 12. Name Bazel Shriver  
 13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary Ann Wise  
 15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

**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) etc  
 (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? ✓

16. (a) Informant Mrs Lillian Huffman  
 (b) Address 1223 N. Elston St  
 17. (a) Burial (b) Date thereof 10 16 41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Rich Hill Mo

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury W.D  
 23. Signature L. T. Casner (M. D. or other)  
 Address Kirkville, Mo Date signed 10/15/41

18. (a) Signature of funeral director D. W. Riley  
 (b) Address Kirkville Mo  
 19. (a) Oct 16/41 (b) James L. Freeman  
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 10

District File Number 11-41-2009

Date Filed NOV 13 1941

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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 W. E. Riley

Licensed Embalmer No. 4181

P. O. Address Hicksville, Me

**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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34139

Registration District No. 1

Primary Registration District No. 1

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

1. PLACE OF DEATH:

(a) County Adair  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME James W. Shriver  
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 w  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 12-17-1852  
(Month) (Day) (Year)

8. AGE: Years 85 Months 9 Days 20 (If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

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 \_\_\_\_\_  
(Burial, cremation, or removal) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day \_\_\_\_\_  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Due to Cancer of bowels  
Significant hyper?  
Due to \_\_\_\_\_

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

Major findings: not done  
Of operations \_\_\_\_\_  
Of autopsy not made

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 T. J. Cameron (M. D. or other) \_\_\_\_\_

Address Kirkwood, Mo Date signed 10/17/41

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

