

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40385**

FILED JAN - 8 1943

Registration District No. **12437**

Primary Registration District No. **3164**

Registrar's No. **402**

1. PLACE OF DEATH:

- (a) County Callaway
 (b) City or town County Superior
 (c) Name of hospital or institution: County Superior
 (If outside city or town limits, write "RURAL" and name of township)
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12/28/42
 (Specify whether years, months or days)

In this community Callaway
 years, months or days

3. (a) PRINT FULL NAME WILLIAM SHAFER

3. (b) If veteran, name war OK 3. (c) Social Security No. 152

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Don't know 6. (c) Age of husband or wife if Don't know years

7. Birth date of deceased Don't know 1858
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>			hr. min.

9. Birthplace N.Y.
 (City, town, or county) (State or foreign country)

10. Usual occupation Teacher

11. Industry or business Don't know

12. Name Don't know

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

14. Maiden name Don't know

15. Birthplace 1
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. G. Moushinski

(b) Address R # 6 Fulton

17. (a) Burial (b) Date thereof 12 29 42
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation County Superior

18. (a) Signature of funeral director C. G. Moushinski

(b) Address R # 6 Fulton

19. (a) Jan 4 - 1943 (b) John Moushinski
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Callaway
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. R # 6 Fulton
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 28
 year 1942 hour 7:00 minute 7 P. M.

21. I hereby certify that I attended the deceased from 11/9 1939 to 12/28 1942

that I last saw him alive on 12/27 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial
with Paralytic
Hypertrophic & Cystic
 Due to _____

Duration

Due to _____

Due to _____

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

Major findings: 137a

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?

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

23. Signature W. D. Payne (M. D. or other)

Address R # 6 Fulton Date signed 12/29/42

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

Rev. 6-17-39

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.