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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10805**

Registration District No. **200** Primary Registration District No. **5727** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Macon**
(b) City or town **Eagle Twp**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Macon**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL.")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mary Elizabeth Shaffer**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married **1 divorced**
6. (b) Name of husband or wife **Oscar Shaffer** 6. (c) Age of husband or wife if alive **59** years
7. Birth date of deceased **Aug 20 - 1886**
(Month) (Day) (Year)

8. AGE: Years **56** Months **7** Days **12** If less than one day hr. min.

9. Birthplace **Macon Co Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **H-W**

11. Industry or business _____

12. Name **Chas Lawrence**

13. Birthplace **Macon Co Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Rachel Parks**

15. Birthplace **Macon Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Chas Shaffer**

(b) Address **Macon Mo**

17. (a) **burial** (b) Date thereof **May 4-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bloomington Cem**
18. (a) Signature of funeral director **Albert Skinner**
(b) Address **Macon Mo**
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **2**
year **1943** hour **4** minute **9** M.
21. I hereby certify that I attended the deceased from **Feb 22**, 19**43** to **March 2**, 19**43**
that I last saw her alive on **Feb. 28**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneumonia**
Due to _____
Duration **8 days**

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

Major findings: _____
Of operations _____
Of autopsy _____

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) (y) Means of injury _____
23. Signature **Arthur L. Linder M.D.**
Address **Dallas Mo** Date signed **3/4/43**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

84
6/43

MAR 16 1943

DEPT

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 Albert S. Keener

Licensed Embalmer No. 75-1

P.O. Address MACON 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 108005

Registration District No. 200

Primary Registration District No. 5724

Registrar's No.

1. PLACE OF DEATH:

(a) County macon
(b) City or town Eagle Junction
(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)

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 _____

3. (a) PRINT FULL NAME Mary E. Shaffer

3. (b) If veteran, name war 0 3. (c) Social Security No. _____

4. Sex F 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 Aug 23 (Month) (Day) (Year)

8. AGE: Years 56 Months 7 Days 10 If less than one day _____ min.

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

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) (Burial, cremation, or removal) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 3/5/43 (Date received local registrar) (b) Yorab Dunkler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 1943 year. hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: hypostatic pneumonia Duration 8 days

Due to (congested type)

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? _____

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

23. Signature Hubree L. Varden M.D. Address Callers, Mo. Date signed 3/7/43

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

SUPPLEMENTARY

S-10805