

FILED NOV 13 1944
Registration District No. 2

Primary Registration District No. 4009

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

1. PLACE OF DEATH:

(a) County Andrew

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

(c) Name of hospital or institution: Dr. Nichols Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)

In this community 9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Nebraska (b) County Nance

(c) City or town Fullerton
(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 F M Sheaff

(b) If veteran, name war no (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20
year 1944 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 11
1944, to Oct 20 1944

that I last saw him alive on Oct 20 1944
and that death occurred on the date and hour stated above.

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

(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased Dec 31 1853
(Month) (Day) (Year)

Immediate cause of death Hypostatic Pneumonia

Due to fracture of left hip

Due to _____

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

8. AGE: Years 90 Months 9 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace McDonnell Co Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Implement Buis

11. Industry or business same

12. Name Wm. L. Sheaff

13. Birthplace Prave city Ill. (City, town, or county) (State or foreign country)

14. Maiden name Caroline Egnor

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

16. (a) Informant Geo. L. Sheaff

(b) Address Fullerton nebr

17. (a) removal to Fullerton (b) Date thereof Oct 21-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fullerton nebr

18. (a) Signature of funeral director Shelter Meierhoffer

(b) Address St. Joseph Mission

19. (a) 10-28-1944 (b) H. S. Hutchman
(Date received local registrar) (Registrar's signature)

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 Dr. Nichols Sanatorium
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury fell

23. Signature J. O. Manning (M. D. or other)

Address Savannah Date signed 10/20/44

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

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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..... *Albert E. Harrington*.....
Licensed Embalmer No. *3258 Me*
P. O. Address..... *St. Joseph, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 2 Primary Registration District No. 4009 Registrar's No. 88

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

1. PLACE OF DEATH:
 (a) County Savannah
 (b) City or town Savannah
(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 F. M. Sheaff
 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 Dec 31 1909
(Month) (Day) (Year)

8. AGE: Years 90 Months 9 Days 9 (If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or 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 20 Year 1944 Hour _____ Minute _____ M.
 21. I hereby certify that I attended the deceased from _____
 that I last saw him _____ alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
hypostatic pneumonia following fracture of left hip femur due to fall
 Due to _____
was treated for cancer of hip was in hospital when he had fall and fractured
 Other conditions _____
(Include pregnancy within 3 months of death)
then developed hypostatic pneumonia
 Major findings: _____
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) accident from fall
 (b) Date of occurrence Oct 17 - 1944
 (c) Where did injury occur? Dr. Nichols Sanatorium
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Andrew Co. Savannah Mo
(City or town) (County) (State)
 While at work? no (Specify type of place) _____ (c) Means of injury _____

23. Signature J. B. Manning, M.D. (M. D. or other) _____
 Address Savannah Mo Date signed 11/16/44

SUPPLEMENTARY

MOTHER FATHER

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

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