

No. 2
-2-43
-17-39
X35697

FILED DEC 28 1945

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 2e

Primary Registration District No. 3001

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Audrain

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

(c) Name of hospital or institution: 213 W. Page 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 20 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain

(c) City or town Vandalia, Mo.

(d) Street No. 213 W. Page 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME FLORA K. SHAW

3. (b) If veteran, name war:

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16 year 1945 hour 7 minute 0 P.M.

21. I hereby certify that I attended the deceased from Oct 29, 1945, to Nov 16, 1945; that I last saw her alive on Oct 31, 1945; and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife JOSEPH H. SHAW

6. (c) Age of husband or wife if alive 1864 years (Month) (Day) (Year)

Immediate cause of death: Pulmonary Hemorrhage

Due to: Chronic Bronchitis

Due to:

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

8. AGE: Years 81 Months 9 Days 5 If less than one day hr. min.

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

10. Usual occupation Housewife

Major findings: Of operations: 13R

Of autopsy:

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

MOTHER FATHER

11. Industry or business:

12. Name James L. Blanchard

13. Birthplace PARMA New York
(City, town, or county) (State or foreign country)

14. Maiden name Loretta Brower

15. Birthplace PARMA New York
(City, town, or county) (State or foreign country)

16. (a) Informant Orpha Shaw

(b) Address Vandalia, Mo.

17. (a) Burial (b) Date thereof 11 19 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Vandalia Cemetery

18. (a) Signature of funeral director W D Waters

(b) Address Vandalia, Mo.

19. (a) Nov 20 1945 (b) Mallie Tugwa
(Date received local registrar) (Registrar's signature)

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 0

23. Signature H. St. Blaud (M. D. or other) _____
Address Vandalia, Mo. Date signed 4/17/45

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

1073

DEC 29 1945

RECEIVED

District Health Officer No. 10

District File Number 12-45-1943

Date Filed DEC. 20. 1945

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..... *A. S. Waters*

Licensed Embalmer No. 4298

P. O. Address..... *Dandalia 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.