

FILED FEB 14 1946

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:
2321 St. Joseph Ave.
(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)

In this community Lifetime
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Buchanan //

(c) City or town St. Joseph /
(If outside city or town limits, write "RURAL")

(d) Street No. 2321 St. Joseph Ave. /
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) /
If yes, name country _____

3. (a) PRINT FULL NAME Emma Drew Shaffer

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife John D. Shaffer

6. (c) Age of husband or wife if alive * 12 years (Day) (Year)

7. Birth date of deceased November 12 1874
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>1</u>	<u>20</u>	br. _____ min.

9. Birthplace St. Joseph Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER { 12. Name William Johnson

13. Birthplace Unknown Scotland /
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Sollars

15. Birthplace St. Joseph Missouri.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Opal Webb

(b) Address 2321 St. Joseph Ave.

17. (a) Burial (b) Date thereof Jan. 4, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Arman W. J. J. J. J.

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) Jan. 7 1946 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2
year 1946 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from 6-1-45
19 to 1-2-46 19 46
that I last saw her alive on 1-1-46
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis & Arteriosclerosis

Due to 201 192

Due to _____

Other conditions Sollars Disease 6 mo
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy 938

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 Opal Webb (M. D. or other) MD

Address 218 N. 4th St. Joseph Date signed 1-3-46

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

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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 *Herward W. Lindenfeld*.....

Licensed Embalmer No. *2728*.....

P. O. Address. *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.