

FILED APR 8 1946

Registration District No. 155

Primary Registration District No. 5579

Registrar's No. 47

1. PLACE OF DEATH:

(a) County JASPER
 (b) City or town RURAL - MINERAL TRUSHP
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
ORONOZO ROUTE 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 59 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
 (c) City or town rural - Mineral TrusHP
 (If outside city or town limits, write "RURAL")
 (d) Street No. Oronozo Route 1
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Charlotte Shafer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced divorced
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased January 31 1887
 (Month) (Day) (Year)

8. AGE: Years 59 Months 0 Days 14
 If less than one day hr. _____ min. _____

9. Birthplace rural Oronozo mo
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER }
 12. Name George H. Buckingham
 13. Birthplace Devonshire England 4
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah B. Buckingham
 15. Birthplace Devonshire England 4
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Will Whitfield 1
 (b) Address Oronozo, Mo, Route 1
 17. (a) Burial (b) Date thereof Feb 16 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Ozark Memorial Cem.

18. (a) Signature of funeral director Knell mortuary
 (b) Address Carthage, Mo
 19. (a) 2-15-46 (b) J. L. Hitchcock
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14
 year 1946 hour 3:45 minute _____ a. M.

21. I hereby certify that I attended the deceased from _____ 19____
Did not attend
 that I last saw him _____ alive on _____ 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cardiac Failure
Due to
Cerebral anemia of
the entire pelvic organs
and the uterine tract.

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 Major findings _____
 Of operation _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, list 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? _____

23. Signature W. J. G. 2 (M. D. or other) DO
 Address 2114 Goplin Date signed 2/14/46
 (Specify type of place) (e) Means of transport _____

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

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.....

Frank W. Kneel....., Registered Apprentice No. *379*
working under my personal supervision.

Signed..... *Emm R. Stuey*

Licensed Embalmer No. *391*

P. O. Address..... *Carthage*

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.

Registration District No. 155

Primary Registration District No. 5579

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Rural
(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 Charlotte Shaper

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

4. Sex F 5. Color or race w 6. (a) Single, 'widowed, married, divorced div

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years 59 Months 0 Days _____ (If less than one day) hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 April year 1946 hour _____ minute _____ M.

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

Immediate cause of death Cardiac failure
Basilonia
of the uterine
Quarries - Jackson
Indes - Jackson
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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
482

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

8801

9875