

V. S. No. 2  
00M-5-43  
Rev. 5-17-39  
I X36871

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20512

FILED JUL 10 1946

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2891

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
Research Hospital   
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 days  
(Specify whether years, months or days)

In this community 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 3631 Bell Street 8  
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME Charles Franklin Shriver

3. (b) If veteran, name war none

3. (c) Social Security No. 487-10-6529

4. Sex male  5. Color or race white

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

6. (b) Name of husband or wife Flonnie Shriver

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased August 5 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67 10 24 hr. min.

9. Birthplace No Record Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Steer Buyer

11. Industry or business John Clay & Co.

MOTHER FATHER

12. Name Frank Shriver

13. Birthplace No Record Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Harriett Rockwell

15. Birthplace No Record 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Flonnie Shriver

(b) Address 3631 Bell Street

17. (a) Burial (b) Date thereof 6/29/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director Gates Funeral Home

(b) Address 1901 Olathe Blvd. K.C.K.

19. (a) 6-29-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26 1946  
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from June 27 1946 to June 26 1946  
that I last saw him alive on June 26, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 day

Due to Hypertension

Due to.....

Other conditions Carcinoma of Prostate  
(Include pregnancy within 3 months of death) 516

Major findings: Of operations.....

Of autopsy none

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) Means of injury 0

23. Signature Thos. E. McMillan M. D. or other

Address 1019 Professional Bldg Date signed 6-29-46

(Licensed Embalmer's Statement on Reverse Side)

Kansas City, Mo

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

R. L. Hoffmann  
Prof. Body.

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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 *O. Ross Blanford*  
Licensed Embalmer No. *4015*  
P. O. Address *411 + State Line*

**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.**