

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

30455

FILED OCT 7 1946

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3998

## 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: St. Joseph Hosp  
 (If not in hospital or institution, write street number & location)  
 (d) Length of stay: In hospital or institution 1 day (Specify whether  
 In this community 1 day  
 years, months or days)

3. (a) PRINT FULL NAME Inf Daughter MARY OLIVER M. SHAW3. (b) If veteran, name war no 3. (c) Social Security No. none4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

7. Birth date of deceased Sept 19 1946  
(Month) (Day) (Year)8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Kansas city MO  
(City, town, or county) (State or foreign country)10. Usual occupation infant

11. Industry or business \_\_\_\_\_

12. Name Oliver M. Shaw13. Birthplace Wellington MO  
(City, town, or county) (State or foreign country)14. Maiden name Lenora A. Bramhall15. Birthplace Kansas city MO  
(City, town, or county) (State or foreign country)16. (a) Informant Oliver M. Shaw(b) Address Lexington, MO17. (a) Removal (b) Date thereof 9-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Lexington, MO18. (c) Signature of funeral director Joseph B. Gumpel(b) Address Lexington, MO19. (a) 9-20-46 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette  
 (c) City or town Hedington  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. St. Joseph  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20  
year 1946 hour 11 minute 20 P.M.21. I hereby certify that I attended the deceased from Sept 20  
1946 to Sept 20 1946  
that I last saw her alive on Sept 20 1946  
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral hemorrhage Duration 1 dayDue to Birth injury 1 day

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)Major findings: Of operations none 1600  
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)  
(c) Means of injury 023. Signature Charles R. Swoboda (M. D. or other)Address St. Joseph's Hospital Date signed 9/20/46

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

**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.....

*not embalmed*....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *W. D. Keane*.....

Licensed Embalmer No. *2983*.....

P. O. Address *Washington MD*.....

**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.**