

FILED NOV 3 1948

State File No. _____

Registration District No. 55

Primary Registration District No. 3011

Registrar's No. 89

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Southside Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Weeks
(Specify whether
In this community 4 Weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Nebraska (b) County Hall 999
(c) City or town Grand Island 25
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME Nancy Linder Shaffer
(b) If veteran, name war No
3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 11
year 1948 hour 6:16 minute _____ A.M. _____ P.M.
21. I hereby certify that I attended the deceased from 10-18-48 to Oct 11 1948
that I last saw her alive on _____ 1948
and that death occurred on the date and hour stated above
Immediate cause of death Cerebral Softening Duration _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Milton Shaffer 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased June 8, 1973
(Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days 3 If less than one day
hr. _____ min. _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

11. Industry or business _____
12. Name William E. Linder
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Linder
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ed. Balcerzak
(b) Address 301 West. Washington
17. (a) Removal (b) Date thereof 10/12/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sylvan Grove, Kas.

18. (a) Signature of funeral director Marshall Funeral Ho
(b) Address Carrollton, Missouri
19. (a) 11/2/48 Sam Michael Cabell
(Date received local registrar) (Registrar's signature) 45

Due to Semility
Due to _____
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:
(c) 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 Dr. [unclear] (M.D. or other) _____
Address Carrollton, Mo Date signed 10/12/48

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

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-1-48

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 P.M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton, 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.