

S. No. 300  
M-10-47  
rv. 5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40359

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

5234

Registrar's No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

44  
3  
8

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

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town K. C. Mass City  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 10 DAYS  
(Specify whether In this community 10 days years, months or days)

3. (a) PRINT FULL NAME MRS. Susan Shafer

3. (b) If veteran, name war A

3. (c) Social Security No. ? none

4. Sex F / 5. Color or race W

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

6. (b) Name of husband or wife CHARLES SHAFER

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased 1881  
(Month) (Day) (Year)

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

67 6 3 hr. min. unknown

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

10. Usual occupation RETIRED

11. Industry or business HOUSEWIFE

MOTHER FATHER

12. Name unknown 9

13. Birthplace " 1  
(City, town, or county) (State or foreign country)

14. Maiden name " 6

15. Birthplace " 1  
(City, town, or county) (State or foreign country)

16. (a) Informant HOPE UND. Co.

(b) Address GALLATIN, Mo

17. (a) REMOVAL (b) Date thereof 12 24 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GALLATIN, MO

18. (a) Signature of funeral director STINE + McCLUES

(b) Address K. C. Mo.

19. (a) 12-24-48 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 31

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

(d) Street No. \_\_\_\_\_ (If rural, give location) 1

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22  
year 1948 hour 2 minute 30 p. M.

21. I hereby certify that I attended the deceased from Dec 13, 1948 to Dec 22, 1948  
that I last saw her alive on Dec 21, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
Due to Arterio Sclerosis

Duration 15 minutes

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

Other conditions 48 85  
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of uterus

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
L. J. Graham (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury 2

23. Signature L. J. Graham (M. D. or other) DD  
Address 418 Bryant St Date signed 12/22/48

JAN 10 1949

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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 Robert H. Reed  
Licensed Embalmer No. 3745  
P. O. Address K. C. 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.**