

FILED MAR 17 1949

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

7724

Do not use this space.

1. PLACE OF DEATH

(a) County Clark Registration District No. 70
 (b) Township Clay Primary Registration District No. 5-274 Registered No. 13
 (c) City 1 (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Marietta Shaw
 (a) Residence, No. Alexandria R.F.D. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF * **

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 5 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 5 15

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Clay Twp.
 (STATE OR COUNTRY) Clark Co. Mo. 0

13. NAME Frank Shaw
 14. BIRTHPLACE (CITY OR TOWN) Winchester
 (STATE OR COUNTRY) Mo. 0

15. MAIDEN NAME Joan Burk
 16. BIRTHPLACE (CITY OR TOWN) Kansas
 (STATE OR COUNTRY) 1

17. INFORMANT Phoeba Ann White
 (ADDRESS) Alexandria, Mo. R.F.D.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Frazer DATE Feb 17 1949

19. FUNERAL DIRECTOR (NAME) H. F. Kircher
 (ADDRESS) Wayland Mo.

20. FILED 3/11- 1949 [Signature]
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 15 1949

22. I HEREBY CERTIFY, That I attended deceased from 1-4- 1949, to 2-15- 1949

I last saw her alive on 2-15- 1949. Death is said

to have occurred on the date stated above, at 6:45 P.M.

The principal cause of death and related causes of importance were as follows:

CEREBRAL HEMORRHAGE

Date of onset

Other contributory causes of importance: IX

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 1949

Where did injury occur? _____
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) [Signature](Address) Kennett Mo.

RECEIVED

District Health Officer Not

District File Number 366

Date Recd. MAR 16 1949

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 W. F. Litch

Licensed Embalmer No. 2611

P. O. Address Wayland

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, above space should be left blank.