

Health,  
& Welfare  
Public  
Service

S. 300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 22 1957

STATE FILE NUMBER **14051**

Registration District No. **238** Primary Registration District No. **4355** Registrar's No. **18**

1. PLACE OF DEATH a. COUNTY <b>New Madrid</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Missouri</b> COUNTY <b>New Madrid</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>New Madrid</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>New Madrid</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>			Length of stay in lb		d. STREET ADDRESS <b>505 Church</b>		(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Monroe</b> Last <b>Shaver</b>				4. DATE OF DEATH <b>April 1, 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 30, 1896</b>		9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <b>Matthews, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Moses Nathaniel Shaver</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Elizabeth Dement</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>488-18-2946</b>		17. INFORMANT Address <b>Carrie Shaver, New Madrid, Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Unknown</b>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4222</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>April 1 only</b> to _____ and last saw <b>him</b> alive on <b>April 1, 57</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Louis Smith MD.</b> (Degree or title)				22b. ADDRESS <b>New Madrid Mo.</b>		22c. DATE SIGNED <b>8 April 57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 3, 57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		23d. LOCATION (City, town, or county) <b>New Madrid, Missouri</b>		(State)
24. FUNERAL DIRECTOR <b>Richards Undertaking Co. New Madrid, Mo.</b>				ADDRESS	25. DATE RECD. BY LOCAL REG. <b>11 April 57</b>	26. REGISTRAR'S SIGNATURE <b>Fay Hedgcock</b>	

(Licensed Embalmer's Statement on Reverse Side)

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072

072

APR 29 1957

DATE RECEIVED APR 12 1957  
NEW MADRID CO. HEALTH CENTER  
P. J. S.

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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Tenny S. Roberts  
Licensed Embalmer No. 2488

P. O. Address New Madrid

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.