

FILED MAY 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH'57 017492
STATE FILE NUMBERRegistration District No. 146 Primary Registration District No. 3026 Registrar's No. 207

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson ✓					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Independence <i>yes</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3516 Crysler			Length of stay in 1b 10 Yrs.		d. STREET ADDRESS 3516 Crysler		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John Easley Shawhan <i>First Middle Last</i>				4. DATE OF DEATH 5-14-1957 <i>Month Day Year</i>					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 29 1867		9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (City and state or country) Lone Jack Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charley Shawhan				14. MOTHER'S MAIDEN NAME Sarah Easley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lena Goode Independence Mo.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis DUE TO (b) arterio-sclerosis DUE TO (c) Senescence Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201								INTERVAL BETWEEN ONSET AND DEATH 6 mos 2 years 2 years	
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		20g. COUNTY		20h. STATE	
21. I attended the deceased from April 1, 1948 and last saw him her alive on May 12, 1957 Death occurred at 4:20 pm on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Chas Allen M.D. (Degree or title)				22b. ADDRESS First Hill Park Independence Mo 5-16-57		22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/17/1957	23c. NAME OF CEMETERY OR CREMATORY Lee's Summit		23d. LOCATION (City, town, or county) Lee's Summit Mo			(State)	
24. FUNERAL DIRECTOR Langsford Funeral Home ADDRESS Summit Mo.				25. DATE RECD. BY LOCAL REG. 5-16-57		26. REGISTRAR'S SIGNATURE James Craig			

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Chas. H. Allen

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.

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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 Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *H. B. Langford*
Licensed Embalmer No. *38*
P. O. Address *Lees Summit*

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.