

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008463  
STATE FILE NUMBER

FILED FEB 24 1958

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 33

|                                                                                                                                                                                             |                                  |                                                                                                                                                             |                                                                                                                                           |                                                                   |                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Saline</u>                                                                                                                                                |                                  |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> |                                                                   |                                                                                                   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Marshall</u>                                                                                                        |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                        | c. CITY OR TOWN <u>Marshall</u> <u>0972</u>                                                                                               |                                                                   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>East Mitchell St</u>                                                                                      |                                  | Length of stay in lb<br><u>5 minutes</u>                                                                                                                    | d. STREET ADDRESS (If outside, give location)<br><u>506 East Mitchell</u>                                                                 |                                                                   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Oliver</u> Middle <u>Marcellus</u> Last <u>Shaw</u>                                                                                      |                                  |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <u>February</u> Day <u>20</u> Year <u>1958</u>                                                                  |                                                                   |                                                                                                   |
| 5. SEX<br><u>Male</u>                                                                                                                                                                       | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb. 18, 1901</u>                                                                                                  |                                                                   | 9. AGE (In years last birthday)<br><u>57</u>                                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Carpenter</u>                                                                             |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>General</u>                                                                                                         | 11. BIRTHPLACE (City and state or country)<br><u>Wellington Missouri</u>                                                                  |                                                                   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                     |
| 13a. FATHER'S NAME<br><u>John Shaw</u>                                                                                                                                                      |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Unknown</u>                                                                                                                 |                                                                                                                                           | 14. NAME OF HUSBAND OR WIFE<br><u>Mrs Leonora Shaw</u>            |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                   |                                  | 16. SOCIAL SECURITY NO.<br><u>499-09-8524</u>                                                                                                               |                                                                                                                                           | 17. INFORMANT<br>Address<br><u>Mrs. Leonora Shaw Marshall Mo.</u> |                                                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>                                  |                                  |                                                                                                                                                             |                                                                                                                                           |                                                                   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>                                                 |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____<br>DUE TO (c) _____                                                           |                                  |                                                                                                                                                             |                                                                                                                                           |                                                                   |                                                                                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                                           |                                  |                                                                                                                                                             |                                                                                                                                           |                                                                   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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<br>Hour _____ Month _____ Day _____ Year _____<br>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 _____ and last saw her alive on _____<br>Death occurred at <u>11 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |                                                                                                                                                             |                                                                                                                                           |                                                                   |                                                                                                   |
| 22a. SIGNATURE (Degree or title)<br><u>P. L. Lawless M.D., Perover Saline Mo.</u>                                                                                                           |                                  |                                                                                                                                                             | 22b. ADDRESS<br><u>Marshall Mo.</u>                                                                                                       |                                                                   | 22c. DATE SIGNED<br><u>2-21-58</u>                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                  |                                  | 23b. DATE<br><u>2-23-1958</u>                                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Machpelah cemetery</u>                                                                           |                                                                   | 23d. LOCATION (City, town, or county) (State)<br><u>Lexington Missouri</u>                        |
| 24. FUNERAL DIRECTOR<br><u>Campbell-Lewis, Marshall Mo.</u>                                                                                                                                 |                                  | ADDRESS                                                                                                                                                     | 25. DATE RECD. BY LOCAL REG.<br><u>2-21-58</u>                                                                                            |                                                                   | 26. REGISTRAR'S SIGNATURE<br><u>Cecil G. Read</u>                                                 |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causative factors.

SEP 18 1963

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 *RW Campbell Jr* .....

Licensed Embalmer No. *3469* .....

P. O. Address *Marshall* .....

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.