

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040191
STATE FILE NUMBER
5348

FILED DEC 8 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY 490
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Length of stay in lb 29 D. 35 Yrs.	d. STREET ADDRESS (If outside, give location) 32 E. Linwood Blvd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HOMER Middle DEWEY Last SHAFFER	4. DATE OF DEATH Month NOVEMBER Day 10 Year 1958
--	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-96	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-------------	------------------------	---	-------------------------	------------------------------------	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist	10b. KIND OF BUSINESS OR INDUSTRY CROWN Drug Co.	11. BIRTHPLACE (City and state or country) Garthage, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13a. FATHER'S NAME Alvin A. Shaffer (D)	13b. MOTHER'S MAIDEN NAME Clara B. Swain	14. NAME OF HUSBAND OR WIFE CERTRAUDE Ethel Shaffer
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 7-22-18 To 1-16-19 196-03-9177	16. SOCIAL SECURITY NO. VA HOSPITAL OFFICIAL RECORDS	17. INFORMANT Address
---	--	-----------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Acute and chronic pyelonephritis, advanced	
	DUE TO (c) Diabetes mellitus	
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? YES <input checked="" type="checkbox"/> NO <input 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.) 160 ft
---	--

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. Attended the deceased from Oct. 13, 1958 to Nov. 10-58 Death occurred at 1:15 a m on the date stated above; and to the best of my knowledge, from the causes stated.	22a. SIGNATURE A. J. WILLIAMS, M.D.	22b. ADDRESS VA Hospital, Kansas City, Missouri	22c. DATE SIGNED 11-10-58
---	--	--	------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE NOV. 11-1958	23c. NAME OF CEMETERY OR CREMATORY SARCOXIE CEMETERY	23d. LOCATION (City, town, or county) (State) SARCOXIE MISSOURI
---	---------------------------	---	--

24. FUNERAL DIRECTOR DW. NEWCOMER'S SONS	ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO	25. DATE RECD. BY LOCAL REG. 11-11-58	26. REGISTRAR'S SIGNATURE New Marshall
---	---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Harold L. Carter*

Licensed Embalmer No. *3935*
P. O. Address *C. C. R.*

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.

