

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002432  
STATE FILE NUMBER

FILED JAN 13 1959

Registration District No. 278

Primary Registration District No. 3034

Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Louisiana MO</u>		c. CITY OR TOWN <u>Louisiana</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pike County Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>700 Georgia</u>	
Length of stay in lb <u>10 years</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA L SHAW</u>			4. DATE OF DEATH Month Day Year <u>Jan 4 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10 1877</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Tray MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>

13a. FATHER'S NAME <u>Fred W. Harbarn</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Eckstein</u>		14. NAME OF HUSBAND OR WIFE <u>John J. Shaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Mrs Helen McCreedy Doolley Louisiana MO</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio-sclerotic hypertensive cardio vascular disease</u>	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>fall out of bed with head injury</u>	

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.) <u>-----</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	<u>-----</u>	

20d. INJURY OCCURRED WHILE AT <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 <u>1949</u> to <u>1-4-59</u> and last saw her alive on <u>1-4-59</u> Death occurred at <u>7:05 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Chas H Lemellen M.D.</u>	22b. ADDRESS <u>Louisiana, Missouri</u>	22c. DATE SIGNED <u>1-4-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan 7, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tray City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Tray Missouri</u>
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24. FUNERAL DIRECTOR <u>Sterne Funeral Home Louisiana Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 12 1959</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITER  
 If possible 2-9-59 BEL  
 Done & added by query of Funeral Director

All diseases in Part I must be causally related.  
 Scurvy, Cholera, etc. must use only standard nomenclature in item 18.

300  
-57

FEB 11 1959

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 *J. B. Sterne* .....

Licensed Embalmer No. *4039*.....  
P. O. Address *Louisiana Mo*

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.