

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020927
STATE FILE NUMBER

FILED JUN 23 1959

Registration District No. 120 Primary Registration District No. Registrar's No. 60

S. 300
v. 1-57

| | | | | | |
|---|---------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Gentry | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Gentry | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Miller Township | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN Miller Township | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION W. of McFall | | Length of stay in lb lifetime | d. STREET (If outside, give location) ADDRESS W. of McFall | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Wilfred Francis Shafer | | | 4. DATE OF DEATH Month Day Year June 19, 1959 | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 1, 1906 | 9. AGE (In years last birthday) 53 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer | | 10b. KIND OF BUSINESS OR INDUSTRY agriculture | 11. BIRTHPLACE (City and state or country) New Market, Indiana | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13a. FATHER'S NAME Bertram Shafer | | 13b. MOTHER'S MAIDEN NAME Susie Rush | | 14. NAME OF HUSBAND OR WIFE Quinnie Shafer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 405-20-2568 | 17. INFORMANT Address Mrs. Wilfred F. Shafer, McFall, 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) Myocardial Thrombosis | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (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) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.) Albany | 20f. CITY, TOWN, OR LOCATION Gentry | COUNTY Mo. | STATE |
| 21. I attended the deceased from 1945 , to 6-19-59 and last saw ^{her} him alive on 6-18-59 Death occurred at 3:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Frank H. Rose, M.D. | | | 22b. ADDRESS Albany, Mo | | 22c. DATE SIGNED 6/20/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE June 22, 59 | 23c. NAME OF CEMETERY OR CREMATORY McFall | | 23d. LOCATION (City, town, or county) (State) McFall Missouri | |
| 24. FUNERAL DIRECTOR Clifford Brooks | | ADDRESS Albany, Mo. | 25. DATE RECD. BY LOCAL REG. 6-20-59 | 26. REGISTRAR'S SIGNATURE Mrs. L. W. Bare | |

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr. Frank H. Rose
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

Student
Signature of Student Embalmer

Signed Donald E Cochell

Licensed Embalmer No. 4868

P. O. Address Albany, 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.