

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028266

AMENDED

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 183

STATE FILE NUMBER

FILED AUG 22 1961

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Audrain</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Length of stay in 1b <u>4 Days</u>		c. CITY OR TOWN <u>Ladonia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wesley George Shafer</u>				4. DATE OF DEATH Month Day Year <u>8 13 1961</u>					
5. SEX <u>Male</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>7-18-1888</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retd. Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Linn County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		
13a. FATHER'S NAME <u>Fredrick Shafer</u>			13b. MOTHER'S MAIDEN NAME <u>Painter</u>			14. NAME OF HUSBAND OR WIFE <u>Maude (Thomas) Shafer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Maude Shafer Ladonia, 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>Acute Circulatory Failure</u> DUE TO (b) <u>Coronary Thrombosis with Myocardial Infarction</u> DUE TO (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>NOT KNOWN</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input 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.)							
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year	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 <u>April 1953</u> to <u>Aug 13 1961</u> and last saw ^{her} him alive on <u>Aug 12 1961</u> Death occurred at <u>1:32</u> a <u>m</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>William W. Jones D.O.</u>				22b. ADDRESS <u>Ladonia Mo</u>				22c. DATE SIGNED <u>8-14-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-15-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Garden Cemetery</u>		23d. LOCATION (City, town, or county) <u>Vandalia, Mo.</u>		STATE		
24. FUNERAL DIRECTOR <u>Wilkey & Bienhoff</u>				ADDRESS <u>Ladonia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>August 15 1961</u>		26. REGISTRAR'S SIGNATURE <u>Blanche Steely</u>	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DATE AMENDED

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

Clyde C. Wilkey

Licensed Embalmer No.

3820

P. O. Address

Perry, MD

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.