

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

S. No. 2
M-9.4-41
5-17-39
X2984

FILED MAR 5 1943
Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 950

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town R. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lane side Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

(c) City or town R. C. Calhoun
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? Ame (Yes or No)

If yes, name country.

3. (a) ~~PRIME~~ SHIFER Hattie June
FULL NAME

3. (b) If veteran, name war.

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22
year 1943 hour 4 minute 40 P M.

21. I hereby certify that I attended the deceased from 2-18
1943, to 2-22 1943
that I last saw her alive on 2-22 1943
and that death occurred on the date and hour stated above.

4. Sex Fe 5. Color or race Wh

6. (a) Single, widowed, married Single
divorced

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive Unknown Years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

Immediate cause of death Septic Peritonitis
Rupture of Appendicitis

Due to Septic Peritonitis
Rupture of Appendicitis

Due to 12:11

Other conditions (Include pregnancy within 3 months of death) 12:11

8. AGE: 8 Years Months Days If less than one day
hr. min.

9. Birthplace Calhoun Mo
(City, town, or county) (State or foreign country)

Major findings: Of operations No Operation

Of autopsy NONE

PHYSICIAN Underline the cause to which death should be charged statistically.

10. Usual occupation Child

11. Industry or business Child

12. Name Jim Shifflet

13. Birthplace Independence
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Jim Shifflet

(b) Address Calhoun Mo

17. (a) Removal (Burial, cremation, or removal) Calhoun Mo

(b) Date thereof 2-24-43
(Month) (Day) (Year)

(c) Place: burial or cremation Calhoun Mo

18. (a) Signature of funeral director J. J. Graham

(b) Address Calhoun Mo

19. (a) 2-22-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature L. J. Graham (M.D. or other) D.O.
Address 511 Chambers Bldg Date signed 2-22-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

John Doe
1234 Main St
Houston, TX

John Doe
1234 Main St
Houston, TX

SHIRT - SHIRT - SHIRT

John Doe
1234 Main St
Houston, TX

John Doe

John Doe

John Doe
1234 Main St
Houston, TX

John Doe

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 _____

Registered Apprentice No. _____
working under my personal supervision.

John Doe
1234 Main St
Houston, TX

Signed _____

John Doe
1234 Main St
Houston, TX

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, fact should be so stated above.