

NOV 21 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

36177  
Do not use this space.

1. PLACE OF DEATH  
(a) County Ray Registration District No. 244  
(b) Township Richmond Mo. Primary Registration District No. 3035 Registered No. 92  
(c) City Richmond Mo. (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 33 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Charles B. Shotwell  
(a) Residence, No. 410 West Main St.   
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Carrie H. Shotwell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 5, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
83 9 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Physician  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Richmond Mo.

FATHER 13. NAME Wm. M. Shotwell  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mayslick Kentucky

MOTHER 15. MAIDEN NAME Amanda McGee  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Camden Mo.

17. INFORMANT (ADDRESS) Dr. L. D. Green Richmond Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Richmond Mo. DATE Oct. 14, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. Thurman Richmond Mo.

20. FILED Oct 15 19 40 malupjacobson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 12, 1940 1940

22. I HEREBY CERTIFY, That I attended deceased from March 1932 to Oct 12 1940  
I last saw him alive on Oct 12 1940 Death is said to have occurred on the date stated above, at 1.30 A.M.  
The principal cause of death and related causes of importance were as follows:  
Broncho Pneumonia or Terminal Pneumonia  
Date of onset \_\_\_\_\_

Other contributory causes of importance: Arteriosclerosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? Yes  
If so, specify \_\_\_\_\_  
(Signed) L. D. Green M. D.  
(Address) Richmond Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 11-13-40

**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.

Signed.....

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, above space should be left blank.**