

FILED JUN 12 1945
Registration District No. **299**

Primary Registration District No. **3057**

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

1. PLACE OF DEATH:
 (a) County **Ray**
 (b) City or town **Richmond**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Lucy Shotwell**
 (b) If veteran, **No** name war _____
 (c) Social Security No. **no**

4. Sex **Female!** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive **11** years **1859**
 7. Birth date of deceased: **Dec.** (Month) **11** (Day) **1859** (Year)

8. AGE: Years **85** Months **5** Days **7** If less than one day _____ hr. _____ min.

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

10. Usual occupation **School Teacher**

11. Industry or business _____

MOTHER FATHER {
 12. Name **William M. Shotwell**
 13. Birthplace **Mayslick Kentucky**
(City, town, or county) (State or foreign country)
 14. Maiden name **Amanda McGee**
 15. Birthplace **Camden Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs L.D. Green**
 (b) Address **Richmond, Mo.**

17. (a) **Burial** (b) Date thereof **May 20, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Shotwell Cemetery**

18. (a) Signature of funeral director _____
 (b) Address **Richmond, Mo.**

19. (a) **May 21-45** (b) **Mrs. Susie W. Shotwell**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Ray**
 (c) City or town **Richmond**
(If outside city or town limits, write "RURAL")
 (d) Street No. **422 E Main St.**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **May** day **18**
 year **1945** hour **3** minute **30** P.M.

21. I hereby certify that I attended the deceased from **May 14**, 19**44**, to **May 18**, 19**45**;
 that I last saw her alive on **May 18**, 19**45**;
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Apoplexy,**
Sudden death,

Due to **Arterio sclerosis,**

Due to _____

Other conditions **Arteries all hard,**
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy **Same,**

PHYSICIAN

 Underline the cause to which death should be charged statistically.

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 **[Signature]** (M. D. examiner)
 Address **Richmond, Mo.** Date signed **5-21-45**

RECEIVED

District Health Officer No. 8,

District File Number

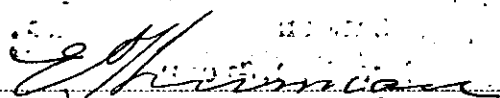
Date Filed

1234
6/11/45

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, #111
Registered Apprentice No. _____
working under my personal supervision.

Signed



Licensed Embalmer No. 2073

P. O. Address. Richmond, 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 this body is not embalmed, fact should be so stated above.