FEB 22 1929

53

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

Do not use this space.

2198

1. PLACE OF DEATH
County Laclede — Registration District No. 449 — File No.
Township Lebanon — Primary Registration District No. 5604 — Registered No. 1522
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Ina B. Shumate
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lena Stickman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 28-1865

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
63	9	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Ky.

PARENTS
10. NAME OF FATHER Benjamin Shumate
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER America Pedrock.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.

14. INFORMANT Ben Shumate
(Address) Lebanon Mo.

15. FILED 1/26, 1929 J. M. Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 15 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1929, to Jan 15, 1929, that I last saw him alive on Jan 15, 1929, and that death occurred, on the date stated above, at 4:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
82A
82D
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Hemiplegia
(duration) 6 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 74A
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical
(Signed) J. C. Scott, M. D
, 19 (Address) Lebanon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Dodson — DATE OF BURIAL: 1/16 1929

20. UNDERTAKER: Palmer — ADDRESS: Lebanon

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.