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.

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

Do not use this space.

1. PLACE OF DEATH
County Chariton — Registration District No. 171 — File No. 9926
Township — Primary Registration District No. 4100 — Registered No. 6
City Keytesville (No. ..... St. ..... Ward)

2. FULL NAME Leora Shoemaker
(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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) February 17th 1929

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
0	1	3	

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

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9. BIRTHPLACE (CITY OR TOWN) Keytesville
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Wm. Grover Shoemaker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Musselfork
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Sarah Carter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Keytesville
(STATE OR COUNTRY) Mo

14. INFORMANT Sarah Shoemaker
(Address) Keytesville Mo

15. FILED March 20, 1929. Zettie Sneed REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-20-1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw her alive on 3-20-, 1929, and that death occurred, on the date stated above, at 10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Blue baby - Patulous foramen Ovale
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Congenital,
(duration) ..... yrs. ..... mos. ..... ds.

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18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
O DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) A W Gillman, M. D
3/20, 1929 (Address) Keytesville

*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 Keytesville
DATE OF BURIAL March 21 1929
20. UNDERTAKER Rucker & Garnett
ADDRESS Keytesville Mo.