MAY 27 1930

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

Do not use this space.

17056

File No. 734

Registered No. 4439

1. PLACE OF DEATH

County Randolph

Township Jackson

City ..... (No. ..... St. ..... Ward)

Registration District No. 734

Primary Registration District No. 4439

2. FULL NAME John Shoaf

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 8 1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	68	5	24	

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) Vermon Co
(STATE OR COUNTRY) Fl

PARENTS

10. NAME OF FATHER Samuel Shoaf

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) N. C.

12. MAIDEN NAME OF MOTHER Susan Sours

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) N. C.

14. INFORMANT Burt Shoaf
(Address) Cairo Mo

15. FILED 5/9, 1930 Albert Skinner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/6 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 14, 1930, to May 5, 1930 that I last saw him alive on May 5, 1930 and that death occurred, on the date stated above, at 5-30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis

97

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Dont Know

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W A Davis, M. D.

5/8, 1930 (Address) Macon Mo

*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	DATE OF BURIAL
Near Altona Kansas	5/9 1930
20. UNDERTAKER	ADDRESS
Albert Skinner	Macon 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.