

MAR 24 1931

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

5266  
File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH  
County Harrison Registration District No. 335  
Township Clay Primary Registration District No. 5470  
City \_\_\_\_\_

2. FULL NAME John Lewis Shoote  
(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)  
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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3. SEX Male  
4. COLOR OR RACE White  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED Widowed  
(OR) WIFE OF Emma Shoote  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-18-1866  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 64 2 0  
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 \_\_\_\_\_

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-18 1931  
17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1931, to Feb 18, 1931, that I last saw him alive on Feb 15, 1931, and that death occurred, on the date stated above, at 9:30 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Blastomycosis with secondary infection  
43A  
92A (duration) 7 yrs. mos. ds.  
CONTRIBUTORY Maternal Regurgitation (SECONDARY) (duration) 2 yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Harrison Co. Mississipi  
(STATE OR COUNTRY)  
10. NAME OF FATHER W. Shoote  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Sarah Crow  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky  
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED At home  
IF NOT PLACE OF DEATH  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? Exam.  
(Signed) C. E. Sixbury, M. D.  
7/9 - 1931 (Address) Famond Iowa

14. INFORMANT Mrs. Emma Shoote  
(Address) Blenhedge, Mo  
15. FILED 7/9 1931  
REGISTRAR

\*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 Andrews Cemetery DATE OF BURIAL 7/9 1931  
20. UNDERTAKER Howard James ADDRESS Engleville 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.

STATE OF MISSOURI, WITH CHANGING JURISDICTION IS A PERMANENT RECORD



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Harrison Registration District No. 333- File No. ....  
Township Clay Primary Registration District No. 0470 Registered No. 4  
City..... (No.....) St. .... Ward)

**2. FULL NAME**

John Lewis Shoats  
(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) M

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

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

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT  
(Address)

15.

FILED

7/19 31 L. J. Costa  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/18 1931

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.  
, 19 (Address)

\*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

19

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-512612

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