

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.

JUN 20 1933

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

Do not use this space.

15580

1. PLACE OF DEATH

1 County Adair Registration District No. 4  
2 Township ..... Primary Registration District No. 3001  
7 City Kirksville Mo (No. ...., ..... St. .... Ward)

File No. ....  
Registered No. 99

2. FULL NAME

James Henry Shoop

(a) Residence, No. Kirksville Mo. St. .... Ward. (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9 29, 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
77 7 22

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 930

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation 74

12. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY)

13. NAME Simon Shoop

14. BIRTHPLACE (CITY OR TOWN) Penn (STATE OR COUNTRY)

15. MAIDEN NAME Welthy C Cookfield

16. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY)

17. INFORMANT Catherine Shoop (ADDRESS) Kirksville Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Novinger DATE 5 23 33 19

19. UNDERTAKER Dee Riley (ADDRESS) Kirksville Mo.

20. FILED 3129 19 33 Mrs C R Becker Registrar.

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 21 May 19 33

22. I HEREBY CERTIFY, That I attended deceased from 16 April, 19 33, to 19 May, 19 33

I last saw him alive on 16 April, 19 33. Death is said to have occurred on the date stated above, at 7 a m

The principal cause of death and related causes of importance were as follows:

Coronary Occlusion Date of onset 4/16/33  
Myocardial Decompensation  
920

Other contributory causes of importance:  
General arteriosclerosis  
Mitral Regurgitation

Name of operation None Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify .....

(Signed) E. S. Smith M. D.  
(Address) Kirksville Mo.

The following is a list of the names of the persons who were present at the meeting held on the 15th day of June, 1947, at the residence of the undersigned, at the address of 1234 Main Street, New York, New York.

The names of the persons present are as follows:

Mr. J. Edgar Hoover  
 Mr. E. A. Tamm  
 Mr. Clegg  
 Mr. Glavin  
 Mr. Ladd  
 Mr. Nichols  
 Mr. Rosen  
 Mr. Tracy  
 Mr. Carson  
 Mr. Egan  
 Mr. Gurnea  
 Mr. Hendon  
 Mr. Pennington  
 Mr. Quinn  
 Mr. Nease  
 Mr. Gandy

The undersigned, J. Edgar Hoover, Director of the Federal Bureau of Investigation, is the only person who was present at the meeting who is not a member of the Federal Bureau of Investigation.

The undersigned, J. Edgar Hoover, Director of the Federal Bureau of Investigation, is the only person who was present at the meeting who is not a member of the Federal Bureau of Investigation.

**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 Adair  
Township  
City Ferksville (No. ....)

Registration District No. 4  
Primary Registration District No. 3001

File No. ....  
Registered No. 99  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. James Henry Shoop 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 (use the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-29-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
71 7 22

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED June 10 19 23 Mrs C H Becker Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 21 19 33

22. I HEREBY CERTIFY, That I attended deceased from ..... to .....

I last saw him ..... alive on ....., 19..... Death is said

to have occurred on the ..... stated above, at .....

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

**SUPPLEMENTARY**

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 COMPLETED AS PRESCRIBED BY LAW.

5-15580