WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should st CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa

REC'D APR 21 1939

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

11492
Do not use this space.

1. PLACE OF DEATH
(a) County Macon 2 Registration District No. 534
(b) Township Primary Registration District No. 4319 Registered No.
(c) City New Cambria (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Albert Shoemaker
(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 Louisa Shoemaker
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mch 22-1872
7. AGE YEARS 67 MONTHS 0 DAYS 21 If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired farmer
9. Industry or business in which work was done, as 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) New Cambria MO

FATHER
13. NAME John C. Shoemaker
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Randolf Co MO

MOTHER
15. MAIDEN NAME Elizabeth Seamans
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Co MO

17. INFORMANT (ADDRESS) Floyd Shoemaker Annabelle MO
18. BURIAL, CREMATION, OR REMOVAL PLACE New Cambria Cemetery DATE Apr 16, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Henry Edwards Bevier MO
20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 13th, 1939
22. I HEREBY CERTIFY, That I attended deceased from Mch 3rd, 1939, to Apr 13th, 1939
I last saw him alive on Apr 13th, 1939. Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Asthma	Apr 10-1939
Other contributory causes of importance: Influenza	Mch 3-1939

95 b 2

Name of operation None Date of —
What test confirmed diagnosis Clinical Was there an autopsy? NO

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? No
If so, specify
(Signed) O O West M. D.
(Address) New Cambria MO

(Licensed Embalmer's Statement on Reverse Side)

SOM-1-1938 I X14028

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

11492
Do not use this space.

1. PLACE OF DEATH
(a) County Macon — Registration District No. 534
(b) Township — Primary Registration District No. 4319 — Registered No. 2
(c) City New Cambria (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Albert Shoemaker
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Louise Shoemaker

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mch 22 1872

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	0	21	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
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) New Cambria Mo

FATHER
13. NAME John C. Shoemaker
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Randolph Co Ohio

MOTHER
15. MAIDEN NAME Elizabeth Seaman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Co Mo

17. INFORMANT (ADDRESS) Floyd Shoemaker Annabelle Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE New Cambria DATE 4-16 1939

19. FUNERAL DIRECTOR (ADDRESS) Henry Edwards Bevier Mo

20. FILED May 13 1939 O. C. West
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 13 1939

22. I HEREBY CERTIFY, That I attended deceased from Mch 3 1939 to 4-13 1939
I last saw h. ..... alive on Apr 13 1939. Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac asthma	

Other contributory causes of importance:
Influenza

Name of operation none Date of .....
What test confirmed diagnosis? Clinical 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) O. C. West, M. D.
(Address) New Cambria Mo

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

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.

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MAY 12 1989