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.

REC'D JUN 8 1939

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

17580
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City K C Mo
Registration District No. 399
Primary Registration District No. 1002
Registered No. 1982
(d) Street No. K C Gen Hospt 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 526 Ross Shoemaker
(a) Residence, No. 2214 East 35 St. 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 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 Myrtle Shoemaker
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb-18-1884
7. AGE YEARS 55 MONTHS 2 DAYS 21 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 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) Ind

FATHER
13. NAME Frank Shoemaker
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind

MOTHER
15. MAIDEN NAME Alma Stanton
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

17. INFORMANT (ADDRESS) Record Clerk K C Gen Hospt
18. BURIAL, CREMATION, OR REMOVAL Brooking Cmt DATE 5-11-39, 19
19. FUNERAL DIRECTOR (ADDRESS) Peter B Gaselina 536 Campbell St
20. FILED May 11, 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-9-39, 19

22. I HEREBY CERTIFY, That I attended deceased from 5-3-39, 19, to 5-9-39, 19
I last saw him alive on 5-9-39, 19 Death is said to have occurred on the date stated above, at 8:50 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary insufficiency with aortic insufficiency and stenosis	

Other contributory causes of importance: 92.1

Name of operation Date of
What test confirmed diagnosis? 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?
If so, specify
(Signed) B H DeMaria, M. D.
(Address) Supt K C Gen Hospt

(Licensed Embalmer's Statement on Reverse Side)

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 compl with the above constitutes grounds for revocation of license.)

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