DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOV 12 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 34389

Registrar's No. 3905

1. PLACE OF DEATH:

(a) County Jackson City

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3830 Troost Ave (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 (Specify whether years, months or days)

In this community 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 3830 Troost Ave (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME John H. Shoemaker

3. (b) If veteran, name war John H. Shoemaker

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cora Shoemaker

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased 12-28-1859 (Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 10 If less than one day ..... hr. ..... min.

9. Birthplace Myerstown (City, town, or county) Pa (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Evans Handyhart Cas Co

FATHER
12. Name Jacob Shoemaker
13. Birthplace ..... (City, town, or county) Pa (State or foreign country)

MOTHER
14. Maiden name Louisa Wolfe
15. Birthplace ..... (City, town, or county) Pa (State or foreign country)

16. (a) Informant's own signature Mrs Cora Shoemaker

(b) Address 3830 Troost

17. (a) Mt Hope (Burial, cremation, or removal) (b) Date thereof 10-11-40 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Hope

18. (a) Signature of funeral director [illegible]

(b) Address K. City

19. (a) 10-9-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8 year 1940 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from Aug 23, 1940 to Oct 8, 1940 that I last saw him alive on Oct 8, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Secondary Hemorrhage	
Due to Following Prostatectomy Oct 4 1940	
Due to	
Other conditions (Include pregnancy within 3 months of death) 137	
Major findings: Of operations Enlarged Prostate	
Of autopsy None	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. P. Miller (M. D. or other)

Address 1800-A-E. 31st Date signed 10/8/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 I X19311

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 George M. Malley

Licensed Embalmer No. 2978

P. O. Address K. C., Kansas

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.