No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26068

R District No. 774 Primary Registration District No. X465 Registrar's No. 1052

1. PLACE OF DEATH:

(a) County St Francois

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

(c) Name of hospital or institution: 1 (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Francois

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

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Benj. Franklin Shoemake

3. (b) If veteran, name war .....

3. (c) Social Security No. 493-63-9474

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Wayne Shoemake

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

7. Birth date of deceased Apr 9th 1885 (Month) (Day) (Year)

8. AGE: Years 56 Months 3 Days 7 If less than one day ..... hr. ..... min.

9. Birthplace French Village Mo (City, town, or county) (State or foreign country)

10. Usual occupation -

11. Industry or business Miner

FATHER 12. Name Wm H. Shoemake

13. Birthplace Ill (City, town, or country) (State or foreign country)

MOTHER 14. Maiden name Sarah E. Wells

15. Birthplace Kinsey Mo (City, town, or county) (State or foreign country)

16. (a) Informant Wayne Shoemake

(b) Address Bonne Terre Mo

17. (a) Burial, cremation, or removal Burial (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation Lone Rock Mo

18. (a) Signature of funeral director Caldwell Bros

(b) Address Bonne Terre Mo

19. (a) 7/30/41 (Date received by local registrar) (b) B B Farris MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th year 1941 hour 12:30 minute P.M.

21. I hereby certify that I attended the deceased from July 17 1941 to ..... 19..... ; that I last saw him alive on ..... 19..... ; and that death occurred on the date and hour stated above.

Immediate cause of death Internal Injuries — Duration

Due to Jury Verdict: We the jury find that the deceased came to his death in stope of St Joseph Lead Co Mine No 1 by falling rock

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations .....

Of autopsy .....

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) Accident

(b) Date of occurrence July 16, 1941 (c) Where did injury occur? Elvins St Francois Mo (City or town) (County) (State)

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

While at work? Yes (e) Means of injury Falling Rock

23. Signature Clarence Claywell (M.D. or other) Coroner

Address Bonne Terre Mo Date signed 7/17/41

(Licensed Embalmer's Statement on Reverse Side)

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

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S..No. 2B
1—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26 068

Registration District No. 774 Primary Registration District No. 4465 Registrar's No. 1052

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

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Elvins
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Benj F. Shoemake
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex
5. Color or race
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Wayne Shoemake
(b) Address Flat River
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-41 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 7/30/41 (Date received by local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 17
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY