S. No. 2
1—8-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2822

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 7

1
3
2

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Macon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Samaritan Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Macon 61
(c) City or town Macon 3 (If outside city or town limits, write "RURAL")
(d) Street No. 2 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Virginia F. Shoemaker
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 14 (Day) 1866 (Year)

8. AGE: Years 78 Months 10 Days 11 If less than one day hr. min.

9. Birthplace Macon Co. Mo 0 (City, town, or county) (State or foreign country)
10. Usual occupation Retired House wife
11. Industry or business
FATHER
12. Name Wright Cross
13. Birthplace Macon Co. Mo 0 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Margaret Hinton
15. Birthplace Mo. 0 (City, town, or county) (State or foreign country)
16. (a) Informant Frank E. Cross
(b) Address Atlanta Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation College Mound Cem
18. (a) Signature of funeral director Stephens & Goodding
(b) Address Macon, Mo.
19. (a) 1/30/45 (Date received local registrar) (b) Nora B. Hunkler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25 year 1945 hour 12 minute 30 A.M.
21. I hereby certify that I attended the deceased from July 1, 1945, to Jan 25, 1945; that I last saw her alive on Jan 25, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	1 month
Due to	
Due to	
Other conditions Pernicious Anemia (Include pregnancy within 3 months of death)	Sev yrs

Major findings:
Of operations
Of autopsy 74a

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 Howard Miller (M. D. ~~or other~~)
Address Macon Mo Date signed 1/29/45

1037

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-45-249
Date Filed FEB 11 1945

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 C L Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, Mo

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, fact should be so stated above.