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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30012

FILED SEP 20 1945

Registration District No. ____ Primary Registration District No. 5004 Registrar's No. 192

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Novinger (Township) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural Route 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: None (Specify whether years, months or days)
In this community: Most of Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Adair 1
(c) City or town: Novinger 6 (If outside city or town limits, write "RURAL")
(d) Street No.: Rural Route 0 (If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Armanda Matildia Shoemaker
3. (b) If veteran, name war:
3. (c) Social Security No.: None
4. Sex: Female 1
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married 1
6. (b) Name of husband or wife: John Oliver Shoemaker
6. (c) Age of husband or wife if alive: 73 years
7. Birth date of deceased: April (Month) 28 (Day) 1876 (Year)
8. AGE: Years 69 Months 3 Days 27 If less than one day ____ hr. ____ min.
9. Birthplace: Hall Co. (City, town, or county) Georgia 1 (State or foreign country)
10. Usual occupation: Home
11. Industry or business:
FATHER
12. Name: William Cathey
13. Birthplace: Hall Co. (City, town, or county) Georgia 1 (State or foreign country)
MOTHER
14. Maiden name: Emily J. Ledford
15. Birthplace: Unknown (City, town, or county) Georgia 1 (State or foreign country)
16. (a) Informant: John Oliver Shoemaker
(b) Address: Novinger, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/29/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Novinger, Mo.
18. (a) Signature of funeral director: Berkley
(b) Address: Kirksville, Missouri
19. (a) 9-2-45 (Date received local registrar) (b) Mrs. J. V. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug day: 25 year: 1945 hour: 5 minute: 15 P. M.
21. I hereby certify that I attended the deceased from: Aug 25 1945 to: Aug 25 1945 that I last saw h. alive on: July 28 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage - fed of chronic disease	
Due to: arteriosclerosis	
Due to: age	
Other conditions (include pregnancy within 3 months of death):	
Major findings: Of operations:	
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: 0
23. Signature: J. S. Gashwiler M.D. (M. D. or other)
Address: Novinger Mo. Date signed: 8/28/45

1049 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-45-1451
Date Filed SEP 17 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 D E Riley

Licensed Embalmer No. 4181

P. O. Address Kirkville

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.