

S. No. 2
OM-5-43
v. 5-17-39
I X36671

FILED JAN 31 1946

Registration District No. 149 Primary Registration District No. 1002

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

1243

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

In this community 11 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles Shoemaker

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased: March 15, 1884
(Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days 8 If less than one day hr. _____ min. _____

9. Birthplace: _____
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER {

12. Name Rufe Shoemaker

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

14. Maiden name Rose Dempsey

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-46
(Month) (Day) (Year)

(c) Place: burial or cremation Rufe Shoemaker

18. (a) Signature of Undertaker Wm A. [Signature]

(b) Address City Mortician

19. (a) 1-11-46 (Date received local registrar)

(b) [Signature] (Registrar's signature)

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. 6 1/2 E. 8 St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 3
year 1946 hour 1 minute 40 A.

21. I hereby certify that I attended the deceased from Jan. 1, 1946 to Jan. 3, 1946
that I last saw him alive on Jan. 3, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Pyelonephritis

Duration _____

Due to _____

Due to _____

Other conditions: 133a
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy: None

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? _____

While at work? _____ (Specify type of place)

(a) Means of injury _____

23. Signature Clark W. Seely (Physician's signature)
Address Med. Dir. Gen'l Hosp. Date signed 1-5-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

St. Vincent

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.....

Wm A. Johnson

Licensed Embalmer No. *3089*

P. O. Address *15 E 7th*

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.