

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-028267**

**FILED VS SEP 8 1959 042**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1000** Registrar's No. **880**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>20 yrs</b>	c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Goforth Nursing Home 1804 Faraon St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2412 Blackwell Road</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>EVERETT</b> Last <b>SHEWMAKER</b>			4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/1866</b>	9. AGE (last birthday) <b>93</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Railroad worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C.G.W. Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Fillmore Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	

13a. FATHER'S NAME <b>Samuel H. Shewmaker</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Kelley</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>498-24-9330</b>		17. INFORMANT <b>Mrs. Mary M. McKahan</b> Address <b>2412 Blackwell St. Joseph, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic, cerebromascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>1 week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Congestive Heart failure</b>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____

21. I attended the deceased from **8-21-59** to **8-28-59** and last saw him <sup>BEK</sup> alive on **8-28-59**  
Death occurred at **12:15P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Richard L. Maginn M.D.</b>		22b. ADDRESS <b>Phys + Surg Bldg 216, St. Joseph, Mo</b>		22c. DATE SIGNED <b>8/28/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8/30/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cemetery</b>	23d. LOCATION (City, town, or County) (State) <b>Savannah Missouri</b>	

24. FUNERAL DIRECTOR <b>Hames Funeral Home</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Sept. 1, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Wm. Clark Goodell</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R.L. Maginn, M.D.

**N.A.S.**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.