

OCT 28 1930

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

29096

1. PLACE OF DEATH

County Benton  
Township Williams  
City..... (No....., .....St. ....Ward)

Registration District No. 59  
Primary Registration District No. 4034

File No.....  
Registered No. 18

2. FULL NAME Mary E Shoemaker

(a) Residence. No.....St., .....Ward. (If nonresident give city or town and State)  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | White | Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles Shoemaker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-14-1850

7. AGE YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min.

79 | 11 | 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Unknwon

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) Unknown

14. INFORMANT William Shoemaker  
(Address) Cole Camp Missouri

15. FILED Oct 28 1930 Harry Bay REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-17 1930

17. I HEREBY CERTIFY That I attended deceased from 9-17-30 to 9-17-30 that I last saw her alive on 9-15-30, 1930, and that death occurred, on the date stated above, at 12:45 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

apoplexy  
14 (duration) yrs. mos. 10 da.  
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH at home

0 DID AN OPERATION PRECEDE DEATH? no DATE OF 1

WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) [Signature] M. D. Address Cole Camp Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Union Cemetery DATE OF BURIAL 9-18-1930

20. UNDERTAKER E. J. Eickhoff ADDRESS Old Camp Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

