

REC'D FEB 16 1939

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

2119
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 243
(b) Township Lincoln Primary Registration District No. 339 Registered No. 1
(c) City Libana (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

550 Cecil Harmon Shoman
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 9 - 1917
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
21 8 22
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Same
9. Industry or business in which work was done, as saw mill, bank, etc. Same
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo.13. NAME Geo Shoman14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark15. MAIDEN NAME "16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "17. INFORMANT (ADDRESS) Geo Shoman18. BURIAL, CREMATION, OR REMOVAL PLACE Finley Cem DATE 1-2-3919. FUNERAL DIRECTOR (NAME) (ADDRESS) B. B. Jones
Buffalo mo20. FILED Jan 16 1939 E. S. Williams Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-1-3922. I HEREBY CERTIFY That I attended deceased from Dec 1 to Jan 1 1939I last saw him alive on Dec 24 1938 Death is said to have occurred on the date stated above, at 5a m.

The principal cause of death and related causes of importance were as follows:

Torcome of tempo. Date of onset 1937Other contributory causes of importance: 47Name of operation X Pay of Lib Date of _____What test confirmed diagnosis _____ Was there an autopsy? no

23. If death was due to external cause (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) L. A. Hester M. D.(Address) Libana, mo

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

RECEIVED
District Health Officer No. 7,
District File Number 7-39-169
Date Filed 2-3-39

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

Licensed Embalmer No.

P. O. Address

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, above space should be left blank.