

NOV 22 1939 MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

36293  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398  
(b) Township Blue Primary Registration District No. 554  
(c) City Independence (d) Street No. \_\_\_\_\_ St.  
(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.

Registered No. 303

2. PRINT FULL NAME Donald Wayne Shumate

(a) Residence, No. 10701 E 23rd St 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) February 24 - 1939  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
7 9  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-3-39  
22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ 19 to \_\_\_\_\_ 19.  
I last saw \_\_\_\_\_ 19. Death is said to have occurred on the date stated above, \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:  
States Pharyngitis  
Hemorrhage into Thymus  
Pulmonary Edema  
Other contributory causes of importance: \_\_\_\_\_  
67

12. BIRTHPLACE (CITY OR TOWN) E 23rd Independence  
(STATE OR COUNTRY) Jackson Co Missouri

13. NAME Samuel H Shumate

14. BIRTHPLACE (CITY OR TOWN) Kansas City  
(STATE OR COUNTRY) Missouri

15. MAIDEN NAME Evelyn Hale

16. BIRTHPLACE (CITY OR TOWN) Kansas City  
(STATE OR COUNTRY) Missouri

17. INFORMANT (NAME) Samuel H Shumate  
(ADDRESS) 10701 E 23rd St. Jackson Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE Oct 5 1939

19. FUNERAL DIRECTOR (NAME) Att. Mitchell  
(ADDRESS) Independence Mo

20. FILED 10/5 1939 L. A. Cook  
Local Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Culture Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (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) Russell W. Jones, M.D.  
360 (Address) Independence Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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**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.**