

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.

JAN 23 1940

Registration District No. 167

Primary Registration District No. 5233

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cedar

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

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME John Aaron Shoemaker

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Nov. 12, 1919
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
20 1 4 _____ hr. _____ min.

9. Birthplace Lockwood, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Day laborer

11. Industry or business _____

MOTHER FATHER

12. Name E. R. Shormaker

13. Birthplace Not known
(City, town, or county) (State or foreign country)

14. Maiden name Louetta Clark

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

16. (a) Informant's own signature Emill P. Shoemaker
(b) Address Greenfield, Mo.

17. (a) Burial (b) Date thereof Dec. 18, 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Collins Cem.

18. (a) Signature of funeral director J. W. Ward
(b) Address Greenfield, Mo.

19. (a) Dec. 16 (b) B. A. Cheek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Dade

(c) City or town Greenfield,
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16
year 1939 hour 10 minute 30 p. M.

21. I hereby certify that I attended the deceased from 10:30 PM
Dec. 16, 1939, to 10:30 PM, 1939;
that I last saw him alive on Dec. 16, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>fracture skull and chest.</u> <u>Due from car accident</u>	
Due to _____	
Due to _____	
Other conditions _____ (Include pregnancy within 3 months of death)	
Major findings: Of operations _____	PHYSICIAN Underline the cause to which death should be charged statistically
Of autopsy _____	

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence December 16, 1939

(c) Where did injury occur? 10 Miles East of Stockton
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Industrial place, On Highway 64
While at work? _____ (Specify type of place)
(e) Means of injury Car

23. Signature Melvin Church (M.D. or other) Dep. Coroner
Address Stockton Mo Date signed 12-22-39

210 PM

closed
21/4 0 PM

RECEIVED

District Health Officer No. 7.

District File Number 1-40-119

Date Filed 1-10-40

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.....

J. W. Ward....., Registered Apprentice No.....
working under my personal supervision.

Signed J. W. Ward
Licensed Embalmer No. 3026

P. O. Address Greenfield, Mass.

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.