

FILED JAN 30 1942

Registration District No. **1**

Primary Registration District No. **1**

Registrar's No. **27**

1. PLACE OF DEATH:

(a) County **Adair**
 (b) City or town **Northwood** (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Wm Laughlin's** (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **13 days** (Specify whether years, months or days)
 In this community **13 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Macon**
 (c) City or town **Bever** (If outside city or town limits, write "RURAL")
 (d) Street No. **0** (If rural, give location)
 (e) Citizen of foreign country? **-** (Yes or No)
 If yes, name country **1**

3. (a) PRINT FULL NAME

EMERY SHOEMAKER

3. (b) If veteran, name war **-**

3. (c) Social Security No. **-**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **-** 6. (c) Age of husband or wife if alive **-** years
 7. Birth date of deceased **March 13 1929** (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
12 9 15 - hr. - min.

9. Birthplace **Be Hannibal Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **school boy**

11. Industry or business **-**

MOTHER FATHER { 12. Name **George Shoemaker**
 13. Birthplace **Macon Co. Mo** (City, town, or county) (State or foreign country)
 14. Maiden name **Pearl Ferrell**
 15. Birthplace **Clifton Hill Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **George Shoemaker**
 (b) Address **Bever Mo**

17. (a) **Burial** (b) Date thereof **12-30-41** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bever Mo**

18. (a) Signature of funeral director **H. S. Edwards**

(b) Address **Bever Mo**

19. (a) (Date received local registrar) **10/11** (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **28** year **1941** hour **1** minute **15 P.**

21. I hereby certify that I attended the deceased from **Dec 7**, 19**41**, to **Dec 28**, 19**41** that I last saw him alive on **Dec 28**, 19**41** and that death occurred on the date and hour stated above.

Immediate cause of death **ful. peritonitis**
 Due to **perforated appendix**
 Due to **-**

Other conditions **12/11** (Include pregnancy within 3 months of death)

Major findings: **perforated appendix**
 Of operations **perforated appendix**
 Of autopsy **-**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **-**
 (b) Date of occurrence **-**
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (c) Means of injury **0**
 23. Signature **Paul Laughlin** (M. D. or other) **D.O.**
 Address **Quitwell, Mo** Date signed **1-5-42**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 1-42-161

Date Filed JAN 27 1942

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 H. G. Edwards

Licensed Embalmer No. 1961

P. O. Address Beverly 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1550

Registration District No. 1

Primary Registration District No. 1

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Osage
(b) City or town arks
(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 Emory Shuemaker
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased mar 13 1929
(Month) (Day) (Year)

8. AGE: Years 12 Months 9 Days 15 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Jan 6, 1942 (Date received local registrar) ms. L. Wagner (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 13 Year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-1550