

Registration District No. **930013**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2130a S. Compton
(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 **Alice Cordelia Shoemate**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **John Shoemate** 6. (c) Age of husband or wife if alive **80** years

7. Birth date of deceased **March 1 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 2 30 hr. min.

9. Birthplace **Washington County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Calvin Larimore**

13. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown Unknown**

15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. L.T. Key**

(b) Address **2130a S. Compton**

17. (a) **Burial** (b) Date thereof **6-3-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Licking, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**

19. (a) **JUN 1 1944** (b) **J. A. Beebech**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Texas** **107**
(c) City or town **Licking**
(If outside city or town limits, write "RURAL") **N.R.**
(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 **May** day **31**
year **1944** hour **3:45** minute **P.** M.

21. I hereby certify that I attended the deceased from **April 1**, 19**44**, to **May 31**, 19**44**,
that I last saw **her** alive on **May 30**, 19**44**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma Stomach** Duration **?**

Due to _____

Due to _____

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

Major findings: **Generalized abdominal Carcinomatosis** PHYSICIAN _____
Of operations _____
Of autopsy _____
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 **W. J. ...** (M. D. or other) _____
Address **539 N Grand** Date signed **6/1/44**

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

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..... *J. W. Wilkinson*.....

Licensed Embalmer No..... *3575*.....

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, fact should be so stated above.