

S. No. 2
M-2-43
7-5-17-39
-1 X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 3 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

McC...
16345
State File No.

Registration District No. ... Primary Registration District No. **3000** Registrar's No. **139**

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

1. PLACE OF DEATH:
(a) County **Adair**
(b) City or town **Kirkville**
(c) Name of hospital or institution: **Laughlin Hospital**
(d) Length of stay: In hospital or institution **1 hr.**
In this community **Life**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Adair**
(c) City or town **Shelbyville**
(d) Street No. **General Delivery**
(e) Citizen of foreign country? **No.**

3. (a) PRINT FULL NAME **Chester Shoop**
(b) If veteran, name war
(c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **15** year **1947** hour **7** minute **35 P.** M.
21. I hereby certify that I attended the deceased from **May 15**, 19**47**, to time of death, 19**47**.
that I last saw him alive on **May 15**, 19**47**, and that death occurred on the date and hour stated above.

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: **October 23 1894**
(Month) (Day) (Year)

Immediate cause of death **Heart failure into rt ventricle of brain.** Duration **12 hrs.**
Due to **Unknown**

8. AGE: Years **52** Months **6** Days **22** If less than one day hr. min.

Due to ...
Other conditions (Include pregnancy within 3 months of death)
Major findings: **g3A**

9. Birthplace **Adair Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Agony**

12. Name **Daniel S. Shoop**

13. Birthplace **Adair Co. Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Mathew Brown**

15. Birthplace **Adair Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Guy S. Shoop**
(b) Address **Kirkville, Mo.**

17. (a) **Burial** (b) Date thereof **5-20-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Hill Cemetery**
18. (a) Signature of funeral director **Oris J. Lambert**
(b) Address **Kirkville, Mo.**

19. (a) **5-24-47** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Underline the cause to which death should be charged anatomically.

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 **2**
23. Signature **Tom Clue** (M. D. or other) **MD**
Address **Kirkville Mo** Date signed **5/17/47**

RECEIVED
District Health Officer No. 42
District File Number 642-930
Date JUN - 2 1941

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, _____

working under my personal supervision.

Signed _____ Registered Apprentice No. _____
Laurence M. Billo
Licensed Embalmer No. *9375*
P. O. Address *Kirkville, Mo.*

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.