

No. 300  
0.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16168

State File No. ....

2297

FILED JUN 9 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City,</b>	c. LENGTH OF STAY (in this place) <b>56 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION. <b>6417 East 12 St.</b>		e. STREET ADDRESS (If rural, give location) <b>6417 East 12 St.</b>	<b>3218</b> <b>0</b>

3. NAME OF DECEASED (Type or Print) a. (First) <b>Charles</b> b. (Middle) <b>Oliver</b> c. (Last) <b>Shoemaker</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>May 19 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 9, 1889</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic-</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Aurora, Nebraska</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Owen Shoemaker</b>	13b. MOTHER'S MAIDEN NAME <b>Jane DeBolt</b>	14. NAME OF HUSBAND OR WIFE <b>Marie Gertrude Shoemaker</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes World War I</b>	16. SOCIAL SECURITY NO. <b>496-16-9770</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Marie Shoemaker</b>	ADDRESS <b>6417 E. 12th</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary edema</b>		<b>1 day</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Carcinoma of the lungs</b> DUE TO (c) <b>Primary</b>		<b>2 yrs.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<b>162x</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Apr. 29, 1954, to May 19, 1954, that I last saw the deceased alive on May 19, 1954, and that death occurred at 10:30 A. m., from the causes and on the date stated above.

23a. SIGNATURE <b>Glenn W. Springer, D.O.</b>	23b. ADDRESS <b>5902 St. John ave. Kansas City, Mo.</b>	23c. DATE SIGNED <b>5-20-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>5-22-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>5-21-54</b>	REGISTRAR'S SIGNATURE <b>Geraldine Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs C.L. Forster</b>	ADDRESS <b>Funeral Home Kas. City, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

JUN 9 1954

PLD - 5903  
Ch. 3154

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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Joe B. Yoder*

Licensed Embalmer No. 417  
P. O. Address N.C.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.