

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31381

State File No.

FILED SEP 20 1954

BIRTH NO.		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>2052</u>		Registrar's No. <u>338</u>											
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>				b. COUNTY <u>Pettis</u>									
b. CITY OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>55 years</u>		c. CITY OR TOWN <u>Sedalia</u>		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 <u>Bothwell Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>640 East 15th Street</u>				<u>080%</u>									
3. NAME OF DECEASED (Type or Print) <u>MAYME SHOMAKER</u>			a. (First) <u>MAYME</u>			b. (Middle) <u>SHOMAKER</u>			c. (Last) <u>SHOMAKER</u>								
4. DATE OF DEATH <u>Sept 13, 1954</u>		(Month) (Day) (Year)		5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 31, 1872</u>		9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months Days		IF UNDER 2 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (City and State or Foreign Country) <u>Okeana, Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13a. FATHER'S NAME <u>William Jolliff</u>				13b. MOTHER'S MAIDEN NAME <u>Rachel Rainey</u>				14. NAME OF HUSBAND OR WIFE <u>L. E. Shomaker</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT'S SIGNATURE OR NAME <u>Clarice Shomaker, Sedalia, Missouri</u>				ADDRESS					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage- Rt. Hemiplegia</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3hr s.</u>					
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio- Vascular Disease and Uremia.</u>								3 months					
				DUE TO (c) <u>First Cerebral Accident- 3 months ago.</u>													
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION <u>Medical only.</u>								20. AUTOPSY? <u>1221</u> No <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None.</u>				21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)									
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None.</u>				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?									
22. I hereby certify that I attended the deceased from <u>over 20 yrs</u> , to <u>Sept. 13th, 1954</u> , that I last saw the deceased alive on <u>Sept. 13th, 1954</u> , and that death occurred at <u>4:54 P.M.</u> from the causes and on the date stated above.																	
23a. SIGNATURE <u>Jno. B. Carlisle, M.D.</u>						23b. ADDRESS <u>Sedalia, Missouri.</u>						23c. DATE SIGNED <u>9-15-54.</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				24b. DATE <u>15 Sept 1954</u>				24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>				24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>					
DATE REC'D BY LOCAL REG. <u>9-15-54</u>				REGISTRAR'S SIGNATURE <u>Jovonia Lewis, Deputy</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>D. Wickhart</u>				ADDRESS <u>Sedalia, Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

QUESTIONS? FUNERAL HOME

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.....
Russell C. Maog

Licensed Embalmer No. *4809*

P. O. Address *Sedalia,*

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.