

FILED NOV 15 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34235

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4697

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Veterans Adm. Hospital		d. STREET ADDRESS 1835 Spruce	
3. NAME OF DECEASED (Type or print) First Middle Last Juanita J. Shoemaker		4. DATE OF DEATH Oct. 28, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	11. BIRTHPLACE (City and state or country) Butler, Missouri
13. FATHER'S NAME JAMES E. JONES		14. MOTHER'S MAIDEN NAME JULIA BADGET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes: WW I		16. SOCIAL SECURITY NO. ---	
17. INFORMANT VA Hospital Records, Kansas City, Mo		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PANCREATITIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) --- DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			INTERVAL BETWEEN ONSET AND DEATH 48 HRS. 6870
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ---	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. ---		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) ---	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE ---	
21. Attended the deceased from Oct. 27, 1956 to Oct. 28, 1956 Death occurred at 7:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Edward C. Graves, M.D. (Degree or title) D		22b. ADDRESS VA Hospital, Kans City, Mo	
22c. DATE SIGNED 10-28-56			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT. 30. 1956	23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY	23d. LOCATION (City, town, or county) (State) BUTLER MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMB'S SONS ADDRESS 1331-BRUSH CREEK KANSAS CITY MO		25. DATE RECD. BY LOCAL REG. 10-30-56	26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56All
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Edward C. Graves

MEDICAL CERTIFICATION

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.....
Richard L. Rogers

Licensed Embalmer No.

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.