

Health, Welfare, Public Service

300 1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 65 Primary Registration District No. 4117 Registrar's No. 155

1. PLACE OF DEATH a. COUNTY <u>Chariton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u>			
-b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rothville</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rothville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>LeRoy</u> ^{First} <u>Shoop</u> ^{Middle} <u>Shoop</u> ^{Last}				4. DATE OF DEATH <u>Feb 17-1957</u> ^{Month} ^{Day} ^{Year}			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18-1879</u>		9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	11. BIRTHPLACE (City and state or country) <u>Rothville Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Shoop</u>				14. MOTHER'S MAIDEN NAME <u>Lucretia Scott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>L</u>	17. INFORMANT <u>Floyd Shoop Rothville Mo</u> ^{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) <u>Uremia.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Multiple Metastases of Adenocarcinoma.</u> DUE TO (c) <u>Adenocarcinoma of Stomach.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Severe Corbacia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year - 3 mo.</u> <u>1 year.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>—</u>				
20c. TIME OF INJURY Hour <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>—</u> a. m. <u>—</u> p. m. <u>—</u>			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION <u>—</u>		COUNTY <u>—</u> STATE <u>—</u>		
21. I attended the deceased from <u>11/20 55</u> to <u>2/17 57</u> and last saw her/him alive on <u>2/12/57</u> . Death occurred at <u>2/17/57</u> <u>1 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>D. W. Behrman M.D.</u>				22b. ADDRESS <u>Brookfield, Mo.</u>		22c. DATE SIGNED <u>2/19/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2/19/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rothville</u>		23d. LOCATION (City, town, or county) (State) <u>Rothville Mo</u>			
24. FUNERAL DIRECTOR <u>A. S. Lipard</u>			ADDRESS <u>—</u>	25. DATE RECD. BY LOCAL REG. <u>2/19/57</u>	26. REGISTRAR'S SIGNATURE <u>Mildred France</u>		

(Licensed Embalmer's Statement on Reverse Side)

30 OCT 1943
S. 1111 100

1943

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.....
A. L. Leopold

Licensed Embalmer No. *39*

P. O. Address *Wendon*

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.