

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002047
STATE FILE NUMBER

FILED JAN 27 1959 Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 24

300
1-57

1. PLACE OF DEATH a. COUNTY <i>Livingston</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Clay</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Chillicothe</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kearney</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital</i>	Length of stay in 1b <i>43 hours</i>	d. STREET ADDRESS (If outside, give location) <i>None</i>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>Lee</i> Last <i>Shoemaker</i>			4. DATE OF DEATH Month <i>January</i> Day <i>17</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 13, 1907</i>	9. AGE (In years last birthday) <i>51</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>4</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>	11. BIRTHPLACE (City and state or country) <i>Sumner, Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13a. FATHER'S NAME <i>Benjamin F. Shoemaker</i>		13b. MOTHER'S MAIDEN NAME <i>Ada Eve</i>	14. NAME OF HUSBAND OR WIFE <i>Gladys Shoemaker</i>			

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>498-07-4580</i>	17. INFORMANT <i>Frank A. Selder, Kansas City, Missouri</i>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Concussion</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Injuries from auto accident.</i>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) <i>Auto accident.</i>	
20c. TIME OF INJURY Hour <i>4</i> p.m. Month <i>Jan</i> Day <i>16</i> Year <i>59</i>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, store, street, office bldg., etc.) <i>State Highway</i>	20f. CITY, TOWN, OR LOCATION <i>Livingston</i>	COUNTY <i>MO.</i>	STATE
21. I attended the deceased from <i>Jan 15</i> to <i>Jan 17</i> and last saw him alive on <i>Jan 17</i> Death occurred at <i>3 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>W. M. Dowell, M.D.</i>		22b. ADDRESS <i>Chillicothe MO</i>		22c. DATE SIGNED <i>1-19-59</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Jan. 19, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lakeside Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Sumner, Missouri</i>
24. FUNERAL DIRECTOR <i>Hill Funeral Home, Brookfield, Mo.</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>1-19-59</i>	26. REGISTRAR'S SIGNATURE <i>Frances B. Keel</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Gerald I. Wady*

Licensed Embalmer No. *4172*

P. O. Address *Brown*

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.