

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS OCT 24 1960

**-60-037763**

STATE FILE NUMBER

Registration District No. 64 Primary Registration District No. 5244 Registrar's No. 42

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> COUNTY <u>Chariton</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cockrell Township</u>		Length of stay in 1b <u>Approx life</u>		c. CITY OR TOWN <u>Cockrell Township</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9 Mi. No. W. Salisbury</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Approx 9 Mi. NW of Salisbury</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Robert Shoemaker Sr.</u>				4. DATE OF DEATH Month Day Year <u>October 18, 1960</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-11-1888</u>		9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General farm</u>			11. BIRTHPLACE (City and state or country) <u>Macon County, Mo.</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>				
13a. FATHER'S NAME <u>John William Shoemaker</u>				13b. MOTHER'S MAIDEN NAME <u>Cynthia Ann West</u>				14. NAME OF HUSBAND OR WIFE <u>- - -</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>none</u>		17. INFORMANT Address <u>Mr. Chris Shoemaker, Huntsville, Mo.</u>								
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>Coronary Thrombosis ?</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Second</u>			
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)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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.)									
20c. TIME OF INJURY Hour s.m. p.m.		Month, Day, Year											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE				
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____. Death occurred at <u>11:50 AM approx</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>H.D. Grunett</u> (Degree or title)				22b. ADDRESS <u>Coroner of Chariton County Keytesville Mo</u>				22c. DATE SIGNED <u>10/18/60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>10/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salisbury City Cemetery Salisbury, Mo.</u>				23d. LOCATION (City, town, or county) <u>Salisbury, Mo.</u> (State)					
24. FUNERAL DIRECTOR <u>Chas. B. Winkelmeyer, Salisbury, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>10-19-60</u>		26. REGISTRAR'S SIGNATURE <u>Opal L. Spence</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Chas B Winhelmege

Licensed Embalmer No. 3842

P. O. Address Salisbury, 1

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