

FILED OCT 23 1946

State File No. _____

Registration District No. 100

Primary Registration District No. 3018

Registrar's No. 74

1. PLACE OF DEATH:

(a) County DEPT
 (b) City or town SALEM
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
NONE
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DEPT 33
 (c) City or town LENOX 0
(If outside city or town limits, write "RURAL") 0
 (d) Street No. _____
(If rural, give location) 0
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME WILLIE FREEMAN SHOEMAKER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife ELLEN SHOEMAKER 6. (c) Age of husband or wife if alive 29 years
 7. Birth date of deceased JAN 29 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 8 16 _____ hr. _____ min.

9. Birthplace MICHIGAN
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

12. Name WILLIAM SHOEMAKER

13. Birthplace PENN
(City, town, or county) (State or foreign country)

14. Maiden name MARIE MATHEN

15. Birthplace OHIO
(City, town, or county) (State or foreign country)

16. (a) Informant Ellen Shoemaker

(b) Address LENOX, MISSOURI

17. (a) BURIAL (b) Date thereof 10-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELKE CEMETERY

18. (a) Signature of funeral director W. L. Spencer

(b) Address SALEM, MISSOURI

19. (a) 10-18-46 (b) M. M. Hart, M. D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 15
 year 1946 hour 7:15 minute P. M.

21. I hereby certify that I attended the deceased from 10-14-46
 _____, 19____, to 10-15-46, 19____
 that I last saw him alive on 10-14-46, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
 Duration ?

Due to _____
 Due to _____

Other conditions Intestinal obstruction
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? M. M. Hart, M.D. (e) Years of injury _____

23. Signature M. M. Hart, M.D. (M. D. or other) M.D.

Address Salem, Mo. Date signed 10/19/46

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 1046580

Date Filed 10-21-46

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address. Salem, Missou

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 this body is not embalmed, fact should be so stated above.

Registration District No. 100 Primary Registration District No. 3018

1. PLACE OF DEATH:
(a) County Deer
(b) City or town Salem
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Willie J Shoemaker
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Jan 2 (Month) (Day) (Year)

8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Mich

10. Usual occupation _____
11. Industry or business _____

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year 1946 (hour) _____ (minute) _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Duration _____
Due to Obstruction
Due to Fecal impaction
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
122B

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

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