

FILED JUL 2 1947

Registration District No. **86**

Primary Registration District No. **5329**

Registrar's No. **18-1947**

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

1. PLACE OF DEATH:

(a) County **CRAWFORD**
 (b) City or town **RURAL OAK HILL TOWNSHIP**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
NEAR OAK HILL MO 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community **61 YEARS**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **CRAWFORD**
 (c) City or town **RURAL**
(If outside city or town limits, write "RURAL")
 (d) Street No. **NEAR OAK HILL MO.**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **HENRY PETER SHOEMAKER**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **CALDONIA WRIGHT** 6. (c) Age of husband or wife if alive **85** years
 7. Birth date of deceased **FEB. 19 1863**
(Month) (Day) (Year)

8. AGE: Years **84** Months **3** Days **12** If less than one day _____ hr. _____ min.

9. Birthplace **NEAR OAK HILL MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMING**

11. Industry or business _____

MOTHER FATHER { 12. Name **DANIEL SHOEMAKER**
 13. Birthplace **PENN.**
(City, town, or county) (State or foreign country)
 14. Maiden name **SARAH SMITH**
 15. Birthplace **OAK HILL MO.**
(City, town, or county) (State or foreign country)

16. (a) Informant **LOGAN SHOEMAKER**
 (b) Address **OWENSVILLE MO. R. 3**

17. (a) **BURIAL** (b) Date thereof **6-2-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BOWEN CEM. RED BIRD MO.**

18. (a) Signature of funeral director **Welford N.H. Winter**

(b) Address **OWENSVILLE MO.**

19. (a) **May 31, 1947** (b) **Paul S. Shandall**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5-31** day _____
 year **1947** hour **4** minute **A.M.**
 21. I hereby certify that I attended the deceased from **5-28**
 19**47**, to **5-28**, 19**47**;
 that I last saw him alive on **5-28**, 19**47**;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Congestive Heart failure **3 days**
 Due to **Hemorrhage cerebral right side** **30 days.**
 Due to **Hypertension, arteriosclerosis** **unknown**
 Other conditions: **Hypertrophy prostate unknown**

Major findings:
 Of operations **none**
 Of autopsy **none**
 Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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? _____ (e) Means of injury _____

23. Signature **Paul S. Shandall** (M. D. or other) _____
 Address **Red Bird Mo.** Date signed **5-31-47**

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 Me
....., Registered Apprentice No.
working under my personal supervision.

Signed Wilford H. H. Winter
Licensed Embalmer No. 3838
P. O. Address Owensville Mo.

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.