

Registration District No. 266

Primary Registration District No. 266-370

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Dent
 (b) City or town RURAL - Spring Creek Sup.
 (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) 2
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days 555

8. (a) PRINT FULL NAME Albert SHINEMAN
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced W.
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 24 1870
 (Month) (Day) (Year)

8. AGE: Years 69 Months 5 Days 8 . If less than one day _____ hr. _____ min.

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

10. Usual occupation MERCHANT

11. Industry or business _____

MOTHER FATHER { 12. Name F. William SHINEMAN
 13. Birthplace MICH.
 (City, town, or county) (State or foreign country)
 14. Maiden name Rose BARNES
 15. Birthplace Tennessee
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. L. Shumaker
 (b) Address Salem, Mo.

17. (a) Burial (b) Date thereof April 4 - 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Odd Fellows Cem. Sullivan, Mo.

18. (a) Signature of funeral director Carl J. Spencer
 (b) Address Salem, Mo.

19. (a) April 4 1940 (b) A. E. Butler, Mo.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dent
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
 year 1940 hour 1:05 minute A.M.

21. I hereby certify that I attended the deceased from 4-1-40, 19____, to 4-1-40, 19____;
 that I last saw him alive on 4-1-40, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death broncho-pneumonia
Due to Myocarditis, arteriosclerosis
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

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? _____
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Jas D. Hinkel (M. D. or other) D.O.
 Address Salem, Mo. Date signed 4-4-40

WHILE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

1 X1951

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.

District Health Officer No. 6,

District File Number 540 571

Date Filed 5-14-40

Signed

Wm. W. McDonald

Licensed Embalmer No.

3806

P. O. Address

Salem, 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, above space should be left blank.