

FILED JUL 13 1948  
Registration District No. 228

Primary Registration District No. 5466

Registrar's No. 532

1. PLACE OF DEATH:

(a) County: Greene  
(b) City or town: Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Ozark Osteopathic Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: 10 hours  
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Greene  
(c) City or town: Springfield - Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No.: R. F. D. # 10  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME: Louie E. Schumacher

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex: Male 5. Color or race: white  
6. (a) Single, widowed, married, divorced, single  
6. (b) Name of husband or wife: \_\_\_\_\_ 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years  
7. Birth date of deceased: September 25, 1904  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
43 9 5 hr. min.

9. Birthplace: Greene Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: Farming

12. Name: John D. Schumacher

13. Birthplace: Springfield Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name: Caroline Hopp

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

16. (a) Informant: Anna Schumacher

(b) Address: Springfield Mo.

17. (a) Burial (b) Date thereof: 7-4-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Bellview Cemetery

18. (a) Signature of funeral director: J.W. Klingner & Co.

(b) Address: Springfield Mo.

19. (a) 7-2-48 (b) W. H. Handy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30, year 1948 hour 1 minute 43 A. M.

21. I hereby certify that I attended the deceased from 6-28, 1948, to June 30, 1948  
that I last saw him alive on June 30, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Toxemia of diabetes.

Due to: Acute Hepatitis

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsies: \_\_\_\_\_

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: William J. [unclear] M. D. or other \_\_\_\_\_  
Address: Springfield Mo. Date signed: 7-2-48

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

JUL 24 1958

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

Signed.....

*Ogle Stone Jr*

Licensed Embalmer No.....

*4174*

P. O. Address.....

*Springfield*

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.