

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY OR TOWN Springfield		c. CITY OR TOWN Springfield	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 817 N. Rogers		e. STREET ADDRESS (If rural, give location) 817 N. Rogers	

3. NAME OF DECEASED (Type or Print) SAMUEL	a. (First) W.	b. (Middle) SHEWMAKER	c. (Last)	4. DATE OF DEATH (Month) May (Day) 22 (Year) 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 16 April 1869	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James P. Shewmaker	13b. MOTHER'S MAIDEN NAME Minerva Jane Rockhold	14. NAME OF HUSBAND OR WIFE Lula D. Shewmaker
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Lula D. Shewmaker	ADDRESS Springfield, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sub Arachnoid Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 5-4-53 5-22-53
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 330X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **5-4-1953**, to **5-22-1953**, that I last saw the deceased alive on **5-22-1953**, and that death occurred at **6:22P.M.**, from the causes and on the date stated above.

23a. SIGNATURE A. E. Feller (Degree or title) M.D.	23b. ADDRESS 609 Cherry Springfield, Mo.	23c. DATE SIGNED 5-22-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-25-53	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield Mo.
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DATE REC'D BY LOCAL REG. 5-27-53	REGISTRAR'S SIGNATURE Robert Williamson	25. FUNERAL DIRECTOR'S SIGNATURE J.W. KLINGNER & CO.	ADDRESS Springfield, Mo
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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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 49.....

H. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.