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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

19871

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. .....

City Sheridan (No. ISOLATION HOSPITAL St. ..... Ward)

File No. .....

Registered No. 5896

2. FULL NAME Phillips Sheridan

(a) Residence. No. 3933 S Bway St., 24 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt.	40	"	"	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer unknown

9. BIRTHPLACE (CITY OR TOWN) unknown 31
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER James Sheridan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
(STATE OR COUNTRY)

14. INFORMANT [illegible]
(Address) ISOLATION HOSPITAL

15. FILED MAY 21 1931 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-22 1931

17. I HEREBY CERTIFY, That I attended deceased from 5-20, 1931, to 5-22, 1931 that I last saw him alive on 5-22, 1931, and that death occurred, on the date stated above, at 10:30 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis - Meningococcic

18 1112 (duration) yrs. mos. ? ds.

CONTRIBUTORY (SECONDARY) Pulmonary edema

(duration) yrs. mos. — ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Lab

(Signed) L. F. Kompare, M. D.

, 19 (Address) ISOLATION HOSPITAL

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary Cem	May 25 1931
20. UNDERTAKER	ADDRESS
Thos J Finan	1519 S Grand