

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

Do not use this space.

31917

1. PLACE OF DEATH

County Monroe
Township Union
City Union (No. _____) St. _____ Ward _____

Registration District No. 5-80
Primary Registration District No. 5-777

File No. _____
Registered No. 5

2. FULL NAME

James Courtland Sherdon

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dollie Elsie Sherdon

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10/30/1869

7. AGE YEARS - 81 MONTHS 10 DAYS 18 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Veterinary Surgeon
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

FATHER 13. NAME Osley Sherdon

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

MOTHER 15. MAIDEN NAME Janie Sherdon

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

17. INFORMANT (ADDRESS) Mrs. J. C. Sherdon

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE 9/18 1931

19. UNDERTAKER (ADDRESS) Fred L. Thompson

20. FILED 9/18 1931 E. C. Brooks Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/18 1931

22. I HEREBY CERTIFY, That I attended deceased from Sept. 17 1931, to Sept. 18 1931.
I last saw him alive on Sept. 18 1931. Death is said to have occurred on the date stated above, at 8:30 a.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset Sept. 17
11:30

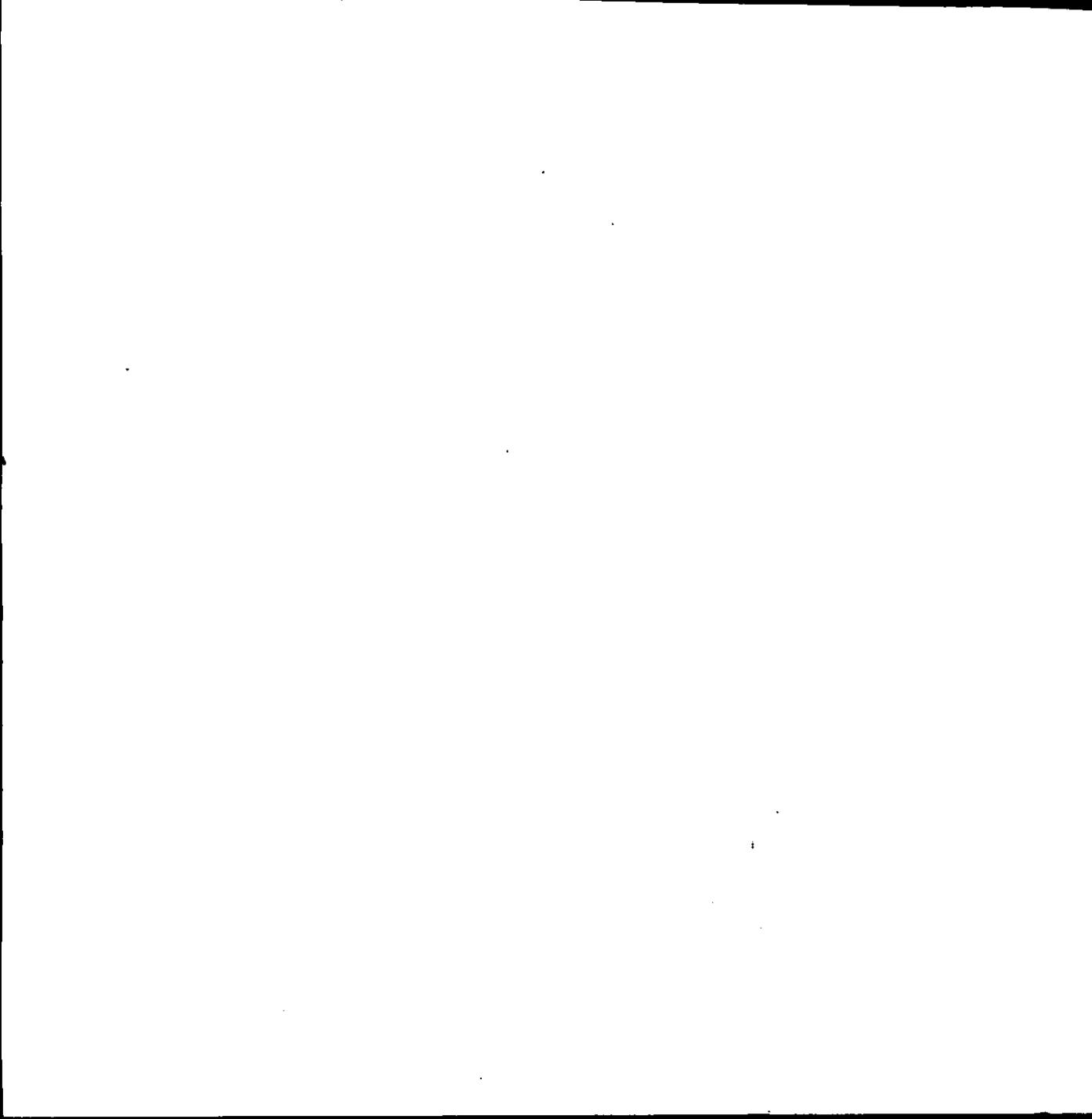
Other contributory causes of importance:
Pneumonia 2 or 3 days

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) 9/18/31 A. P. Turner M.D.
(Address) Madison Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Monroe Registration District No. 180 File No. _____
 Township Union Primary Registration District No. 3777 Registered No. 3
 City _____ (No. _____) Sl. _____ Ward _____

2. FULL NAME

James Courtland Sheridan
 (a) Residence No. _____ St. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____
 (Address) _____

15. FILED 1-7-21 1921 EC P. Priddy
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/18 1931

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cerebral hemorrhage
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Pneumonia
Hypostatic Pneumonia
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. P. Stourish, M.D.
 , 19____ (Address) Madison, Mo.

*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 _____

19

20. UNDERTAKER _____

ADDRESS _____

SUPPLEMENTARY

NO FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-31917