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

FEB 24 1939

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

2930
Do not use this space.

1. PLACE OF DEATH
(a) County Linn
(b) Township
(c) City Brookfield
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 496
Primary Registration District No. 3025
Registered No. 10

2. PRINT FULL NAME Patricia Jane Shermuly
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 26 1939
7. AGE YEARS MONTHS DAYS 3 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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) Brookfield Mo

FATHER
13. NAME Patrick J Shermuly
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macomb Ill

MOTHER
15. MAIDEN NAME Grayce Warner
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Patrick J Shermuly Marceline Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Killgard DATE 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jas M Laughlin Marceline Mo
20. FILED Feb 1 1939 Jno Lucas
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-30 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/26 1939, to 1-29 1939
I last saw her alive on 1/29 1939. Death is said to have occurred on the date stated above, at 9:30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Sealed Hemorrhage	3 da
160 B	

Other contributory causes of importance:

Birth Injury	3 da

Name of operation 0 Date of 0
What test confirmed diagnosis? Phys Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? 0 Date of injury 0, 19
Where did injury occur? 0
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury 0
Nature of injury 0

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify No
(Signed) [signature], M. D.
(Address) Brookfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-39-97
Date Filed FEB 8 1939

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, James M Laughlin, or by .....

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

Signed Jas M Laughlin

Licensed Embalmer No. 1274

P. O. Address Marceline

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

2930
Do not use this space.

1. PLACE OF DEATH
(a) County Linn — Registration District No. 496
(b) Township — Primary Registration District No. 3025 — Registered No.
(c) City Brookfield — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Patricia Jane Sherminly
(a) Residence, No. ..... St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1 - 26 1939
7. AGE — YEARS — MONTHS — DAYS 3 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marcelini Mo

17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Killard DATE Feb 2 1939
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED Feb 13 1939 Jno H Lucas Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-30 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... 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? .....
If so, specify .....
(Signed) J. G. McLarney, M. D.
(Address) Brookfield Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.