GEO'D MAY 16 1939

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

15097
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 1 Registration District No. 400
(b) Township Prairie 1 Primary Registration District No. 5553B. Registered No. 97
(c) City ..... (d) Street No. Jackson Co Emergency Hospital 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 Ida F Sherman
(a) Residence, No. 8700 Morrell Independence Mo
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 24-1903
7. AGE YEARS 35 MONTHS 11 DAYS 24 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Work
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) Kansas City Mo

FATHER
13. NAME Henry Davis
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelton Conn

MOTHER
15. MAIDEN NAME Mary E Montagy
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ft Wayne Ind.

17. INFORMANT (ADDRESS) Claude Davis 240 So Cedar Fairmount Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Washington DATE 4/20/39
19. FUNERAL DIRECTOR (ADDRESS) Geo. C. Carson Independence Mo
20. FILED 4/20/1939 Sara G. Barnes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 18 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 6:57 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Nephritis	Apr. 10, 39

Other contributory causes of importance:

Septic infection of throat	Apr. 8, 39

Name of operation none Date of .....
What test confirmed diagnosis? Autopsy Was there an autopsy? yes

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) A. F. Swaney, M. D.
(Address) Deputy Coroner Lee Summit Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1 X12004

115c

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

13097

Do not use this space.

1. PLACE OF DEATH

(a) County: Jackson — Registration District No.: 400

(b) Township: Prairie — Primary Registration District No.: 53-33 B — Registered No.: 92

(c) City: ..... (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: Ida F Sherman

(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: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid

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

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

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	11	24	

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)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ....., 19.... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 4-18, 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
acute Nephritis	
The acute Nephritis was caused by septic throat following a chronic Nephritis	
Other contributory causes of importance: Septic Infection	

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) A. G. Swanepoel M. D.

(Address) Lees Summit Mo

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. HOSPITAL PHYSICIANS should state 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.