

WRITE PEAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

10/10/39

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

34942
Do not stamp this space.

1. PLACE OF DEATH

(a) County Jackson, Registration District No. 399
(b) Township Kaw, Primary Registration District No. 1002
(c) City Kansas City, Mo. (d) Street No. 6420 Penn St., 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

Joseph Walter Sherlock,
(a) Residence, No. 6420 Penn St., 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 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 Emma G. Sherlock,
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-3-1866
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 1 7

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired.
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) Nebraska.

FATHER
13. NAME Joseph Sherlock,

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England,

MOTHER
15. MAIDEN NAME Jane - [unclear]

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England,

17. INFORMANT Emma G. Sherlock,
(ADDRESS) 6420 Penn St., K. C., Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Elmwood, DATE 10/12/39

19. FUNERAL DIRECTOR (NAME) Stine & McClure,
(ADDRESS) 3235 Gillham Plaza, K. C., Mo.

20. FILED 10/10, 1939 W. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 10, 1939.

22. I HEREBY CERTIFY, That I attended deceased from 12/10, 1935, to 10/10, 1939
I last saw him alive on 10-9, 1939. Death is said to have occurred on the date stated above, at 2:00 am
The principal cause of death and related causes of importance were as follows:

Coronary occlusion
94
Other contributory causes of importance: Arteriosclerosis
Date of onset 10/6/39

Name of operation none Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no

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) W. M. Crowe M. D.
(Address) Plaza and Bell - K. C. Mo

Ellis Wilhelmy

Plaza Med

LO 1533

2:00-5:30

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

Registered Apprentice No., working under my personal supervision.

Signed

E. M. Plank

Licensed Embalmer No. 1548

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