

Registration District No. 4-4

Primary Registration District No. 5

Registrar's No. 102

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Ransom City
(c) Name of hospital or institution: 2307 E 85th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
In this community 14 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Charles N. Sherman
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex Male 5. Color or race wh.
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mable Cabell Sherman
6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Oct 12 - 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 19
If less than one day — hr. — min.

9. Birthplace Julip Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business —

MOTHER FATHER { 12. Name Sam Sherman

13. Birthplace no record
(City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs M. Sherman

(b) Address 2307 E 85th

17. (a) Burial (b) Date thereof 12-4-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Adelia Mo

18. (a) Signature of funeral director John P. Schell
(b) Address 6626 Indep. ave. K.C. Mo

19. (a) 12-7-39 (b) Mrs Jos. J. Brennan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Ransom City - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 2307 E 85th
(If rural, give location)
(e) If foreign born, how long in U. S. A. no years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1
year 1939 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 1, 1939
to Oct 18, 1939

that I last saw him alive on Dec 2, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Chronic Myocarditis

Due to Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: 93.0

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)

(e) Means of injury

28. Signature Ho Z. Green (M. D. or other)

Address 909 Grand St Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

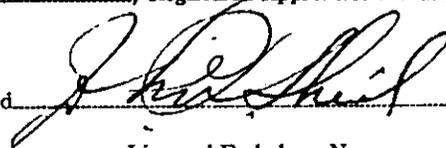
STATEMENT BY LICENSED EMBALMER

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



Licensed Embalmer No.

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.