

No. 2
11-10-39
-17-39
I X21492

APR 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. [Signature] 19158
State File No. _____

Registration District No. 651

Primary Registration District No. 4388

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Demise
(b) City or town Caruthersville, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community 2 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Demise
(c) City or town Caruthersville, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 610 Jaurant. ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Sherman Kirk 620

3. (b) If veteran, 1 name war _____
3. (c) Social Security No. _____

4. Sex male 5. Color or race cal
6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased 6-12-1919
(Month) (Day) (Year)

8. AGE: Years 20 Months 10 Days 20
If less than one day _____ hr. _____ min.

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

10. Usual occupation laborer

11. Industry or business Common labor

12. Name Sherman Kirk

13. Birthplace Caruthersville, Mo
(City, town, or county) (State or foreign country)

14. Maiden name Walter Hambley

15. Birthplace Phillips, Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Samuel Richardson
(b) Address Caruthersville, Mo

17. (a) Burial (b) Date thereof 5-5-1940
(Burial, cremation, or autopsy) (Month) (Day) (Year)

(c) Place: burial or cremation Morganfield, Mo
18. (a) Signature of funeral director H. B. Smith
(b) Address Caruthersville, Mo
19. (a) May 11, 1940 (b) Ada Matier
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 22
year 1940 hour 5 minute 30 AM

21. I hereby certify that I attended the deceased from April 30, 1940 to April 9, May 1, 1940
that I last saw him alive on April 9, May 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
meningitis spinal non specific epidemic

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) none

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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?
585

While at work (Specify type of place) _____
Means of injury _____
23. Signature H. B. Smith (M. D. or other) _____
Address Caruthersville, Mo Date signed 6-11-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

6-40-74

51

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.