

BUREAU OF THE CENSUS  
AUG 16 1940

Registration District No. 365

Primary Registration District No. 5511

Registrar's No. 10

1. PLACE OF DEATH: Wheatland, Mo

(a) County Wheatland

(b) City or town Wheatland, 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 \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

8. (a) PRINT FULL NAME Alcie Berry Sherman

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife John Sherman 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 11, 1865  
(Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Arrow M. Shaplin

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

14. Maiden name Martha E. Hunt

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

16. (a) Informant Mrs Hallie Rorer

(b) Address Wheatland Mo

17. (a) Burial (b) Date thereof 7/27/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Butcher Cove

18. (a) Signature of funeral director J. H. Hyster

(b) Address Wheatland Mo

19. (a) Aug 1-40 (b) Mrs A. Johnston  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wheatland

(c) City or town Wheatland, Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. 0  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19  
year 1940 hour 5 minute 20 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1933, to July - 19 -, 1940;  
that I last saw her alive on July - 15 -, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Multiple Sclerosis 7 or 8 yrs  
Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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? 326  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. S. Johnston M.D. (M.D. or other) \_\_\_\_\_  
Address Wheatland Mo Date signed 7-20-40

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

43

RECEIVED

District Health Officer No. 7.

District File Number

8-40-1198

Date Filed

8-12-40

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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

*J. R. Lacey*

Licensed Embalmer No.

2982

P. O. Address

Wheatland

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.