

No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

38693

318

State File No.

899

Registration District No.

Primary Registration District No. 2001

Registrar's No.

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

1. PLACE OF DEATH
 (a) County GREENE
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 2221 N. Johnston
 (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 _____

3. (a) PRINT FULL NAME KENNETH WARREN SHERRILL
 3. (b) If veteran, name and no. SS 560-18-0639
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Mary C. Sherrill
 6. (c) Age of husband or wife if alive 54 years
 7. Birth date of deceased April 16 1885
 (Month) (Day) (Year)

8. AGE: Years 55 Months 6 Days 19
 If less than one day _____ hr. _____ min.

9. Birthplace Unknown South Dakota
 (City, town, or county) (State or foreign country)

10. Usual occupation Electrician
 11. Industry or business Electrical Worker

MOTHER FATHER { 12. Name George Sherrill
 13. Birthplace Unknown Unknown 9
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Gene Rice
 15. Birthplace Unknown Unknown 7
 (City, town, or county) (State or foreign country)

16. (a) Informant Mary C. Sherrill
 (b) Address Springfield Mo.

17. (a) Burial (b) Date thereof Nov 7 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Wesley Chapel

18. (a) Signature of funeral director G. W. Hughes
 (b) Address Springfield Mo.

19. (a) 11-7-40 (b) W. E. Handley MD
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2221 N. Johnston
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5
 year 1940 hour 1 minute 00 P. M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him alive on Nov 5, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis with Hemorrhage
 Duration 2 yrs?

Due to _____
 Due to 22

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 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? at home

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature Med White (M. D. or other) 5
 Address Carter Greene County Date signed 11-6-40

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 *William May Rhodes*
Licensed Embalmer No. *4071*
P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

X