

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3980

Registrar's No. 6

Registration District No. 735

Primary Registration District No. 3034

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(c) Name of hospital or institution: Hoodland 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME RUSSELL EDWARD SHERWOOD
3. (b) If veteran, name war
3. (c) Social Security No. 499-10-1472

4. Sex Male
5. Color of race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 23 1922
(Month) (Day) (Year)

8. AGE: Years 18 Months 11 Days 8
If less than one day _____ hr. _____ min.

9. Birthplace Glasgow Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Gas Station

11. Industry or business _____
12. Name Wm. E. Sherwood
13. Birthplace Glasgow Mo
(City, town, or county) (State or foreign country)
14. Maiden name Maude A. Ruscher
15. Birthplace Chariton County, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Thomas Sherwood
(b) Address Glasgow Mo
17. (a) burial (b) Date thereof Jan 2, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Glasgow, Mo
18. (a) Signature of funeral director R. P. McFarley
(b) Address Glasgow, Mo.
19. (a) 1/2/41 (b) Seal Sullivan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Howard
(c) City or town Glasgow
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 31
year 1940 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from Dec 25, 1940, to Dec 31, 1940;
that I last saw him alive on Dec 31, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Broncho Pneumonia
Emergency - left thorax
Due to Sheets over throat

Due to _____
Other conditions no
(Include pregnancy within 3 months of death) 115 C

Major findings: _____
Of operations no
Of autopsy no

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?
925 While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Thos. Sullivan (M. D. or other) _____
Address Moberly Mo Date signed 12/31/40

Duration 1 week
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

REV. 5-17-39 I. 11951

RECEIVED

District Health Officer No. 10

District File Number 2-41-414

Date Filed FEB 19 1941

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.....

K.P.M. Cravy

Licensed Embalmer No. 3153

P. O. Address Glasgow, Nw.

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.

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Liberty
(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

3. (a) PRINT FULL NAME

Russell Edw. Sherwood

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

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 18 Months 11 Days 8
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1/2/41 (b) Leah Williams
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 31
year 1940 hour _____ minute _____ M.

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

Immediate cause of death _____
Duration _____

Due to _____
Due to _____

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? _____

While at work _____ (Specify type of place)

(b) Means of injury _____

23. Signature Thos S. Flemura (M. D. or other) _____

Address Liberty Mo Date signed _____

SUPPLEMENTAL REPORT

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

