S. No. 2
4-13-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25775

FILED APR 1941

Registration District No. 653 Primary Registration District No. 5864 Registrar's No. 46

1. PLACE OF DEATH:
(a) County Pemiscot
(b) City or town Near Hayti Mo Hayti T
(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 years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pemiscot
(c) City or town Near Hayti Mo
(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.? ..... years.

3. (a) PRINT FULL NAME Rosa Ola Sherrod
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased 8-30-1892 (Month) (Day) (Year)

8. AGE: Years 49 Months 10 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Ridgley Tenn (City, town, or county) (State or foreign country)
10. Usual occupation House Work
11. Industry or business .....
FATHER
12. Name Bud Broglin
13. Birthplace Tenn (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Small
15. Birthplace Tenn (City, town, or county) (State or foreign country)
16. (a) Informant Flora M. Carlton
(b) Address Caruthersville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 12 41 (Month) (Day) (Year)
(c) Place: burial or cremation Dry Bayou
18. (a) Signature of funeral director H. S. Leech
(b) Address Caruthersville Mo
19. (a) 7/27/41 (Date received local registrar) (b) Pearl Pulley (Registrar's signature)
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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 12 day ~~July~~ 12 year 1941 hour 7 minute 30 A.M.
21. I hereby certify that I attended the deceased from March, 1941, to 7-12-, 19 41, that I last saw her alive on 7-12-, 19 41, and that death occurred on the date and hour stated above.

Immediate cause of death Malignancy of Rt. Breast and Ulcers
Due to .....
Due to .....
Other conditions (Include pregnancy within 3 months of death) .....
Major findings: Of operations .....
Of autopsy No

Duration

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature A. J. Shivers (M. D. or other) D
Address Hayti Mo Date signed 7-14-41

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 8 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 James A. Osborn

Licensed Embalmer No. 4185

P. O. Address Caribou, Me

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, fact should be so stated above.

. S. No. 2B
DM—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25775

Registration District No. 653 Primary Registration District No. 5864 Registrar's No. 46

1. PLACE OF DEATH:

(a) County Pemiscot

(b) City or town ..... (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 years, months or days) In this community .....

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 .....

3. (a) PRINT FULL NAME Rosa O Sherrod

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

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

4. Sex F

5. Color or race Wt

6. (a) Single, widowed, married, divorced Wid

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 ..... Months ..... Days ..... 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) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... hour ..... minute ..... M.

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

	Duration
Immediate cause of death: Malignancy of Ut. Breast & Uterus	
Due to: Ca of Cervix	
Due to: of Anemia	
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)

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

While at work? ..... (Specify type of place) (c) Means of injury .....

23. Signature [illegible] (M. D. ~~or other~~)

Address Hayti, Mo. Date signed 9-19-41

SUPPLEMENTARY

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

Hayti Mo.