

S. No. 2  
-11-10-39  
5-17-39  
X21492

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

DEPARTMENT OF COMMERCE  
Bureau of the Census

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

3128

FILED FEB 10 1943

State File No. \_\_\_\_\_

Registration District No. 225

Primary Registration District No. 3063

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Phelps Co.

(b) City or town Rolla, Mo.

(c) Name of hospital or institution: McFarland Hospital  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)

In this community 50 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County DeWitt 33

(c) City or town Rural Doss, Mo. 0  
(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.

3. (a) PRINT FULL NAME Lessie Jane Sheets

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7th year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 4 days \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

4. Sex F. 5. Color or race W.

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

6. (b) Name of husband or wife Troy Oscar Sheets

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased 6 2 1884  
(Month) (Day) (Year)

Immediate cause of death Cerebral of the brain

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

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

8. AGE: Years 58 Months 7 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ripley Co. Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name Don't know

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

14. Maiden name Don't know

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

16. (a) Informant Wardlaw Sheets

(b) Address Salem, Mo.

17. (a) Burial (b) Date thereof 1-9-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mexer Cemetery

18. (a) Signature of funeral director Robert S. Shallick

(b) Address Salem, Mo.

19. (a) 1-38-1943 (b) Rolla, Mo.  
(Date received local registrar) (Registrar's signature)

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) (a) Means of injury \_\_\_\_\_

23. Signature William McFarland (M. D. or other) \_\_\_\_\_  
Address Rolla, Mo. Date signed 1/7/43

MAR 8 1943

**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 \_\_\_\_\_

*Raymond W. Ford*

Licensed Embalmer No. 2910

P. O. Address Salina Mo

**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.**