No. 2
9-4-41
17-39
X

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

17430

State File No.

FILED JUN 8 1943

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 569

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 2 71
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs. 8 mo. 24 da (Specify whether years, months or days)
In this community 2 yrs. 8 mo. 24 da

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 11

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

(d) Street No. 2513 East 20th 1
(If rural, give location)

(e) Citizen of foreign country? P 7 (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME WILLIAM SHERMAN, SR.

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife May Sherman

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased August (Month) 14 (Day) 1871 (Year)

8. AGE:

Years	Months	Days	If less than one day
71	9	11	hr. min.

9. Birthplace Paola (City, town, or county) Kansas (State or foreign country) 1

10. Usual occupation Cigar maker

11. Industry or business Cigar Mfg

FATHER
12. Name William Sherman
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country) 1

MOTHER
14. Maiden name Minnie Monty
15. Birthplace Unknown (City, town, or county) Germany (State or foreign country) 1

16. (a) Informant Records State Hospital
(b) Address St. Joseph, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/26/43 (Month) (Day) (Year)
(c) Place: burial or cremation Paola, Kansas

18. (a) Signature of funeral director Heaton-Beale & Bowman
(b) Address 319 So. 10th Street

19. (a) 5-26-43 (Date received local registrar) (b) Rose Hegog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1943 hour 1 minute 45 P. M.

21. I hereby certify that I attended the deceased from May 23, 1943, to May 25, 1943, that I last saw him alive on May 25, 1943, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	1
Due to Fracture of femur	
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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Geo. M. Bateler (M. D. ~~or other~~)
Address St. Joseph Mo. Date signed 5/26/43

1233

(Licensed Embalmer's Statement on Reverse Side)

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 Moles

Licensed Embalmer No. 3296

P. O. Address St Joseph Mo

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

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

. S. No. 2B
0M—8-21-41
I X29288

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

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 569

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Hosp # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-8-24 (Specify whether
In this community same
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town K. C.
(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 William Sherman, Sr

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 M

6. (b) Name of husband or wife May S.

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

7. Birth date of deceased Aug (Month) 14 (Day) 1871 (Year)

8. AGE: Years 71 Months 9 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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 May day 25
year 1943 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 Hypostatic pneumonia

Due to Fracture of Femur

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1860
38

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence May 21 - 1943

(c) Where did injury occur? State Hosp #2 (City or town) St Joseph (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
State Hospital - fell out of bed.
(Specify type of place)

While at work? (e) Means of injury

23. Signature Geo M. Boteler (M. D. or other)

Address St Joseph Mo Date signed 6/11/43

17430