

S. No. 2
4-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30827

State File No. _____

FILED OCT 13 1944

Registration District No. _____

Primary Registration District No. 5377

Registrar's No. 231

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

1. PLACE OF DEATH:

(a) County Ile Kalb

(b) City or town Rural, Grant Jun
(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) 1

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community entire life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ile Kalb

(c) City or town Mayville Rural
(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 Mary Belle Sherard

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1944 hour 3:45 minute 0 P. M.

21. I hereby certify that I attended the deceased from April 7, 1942 to Sept 26, 1944
that I last saw h. or alive on Sept 26, 1944
and that death occurred on the date and hour stated above.

4. Sex 7.1 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elza F. Sherard 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased April 4 - 1868
(Month) (Day) (Year)

Immediate cause of death Complete intestinal obstruction caused by tumor of veterans

Due to said bowel - probably malignant

Due to _____

8. AGE: Years 76 Months 5 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace Ile Kalb Co Missouri
(City, town, or county) (State or foreign country)

Other conditions Chronic edematous?
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____

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

10. Usual occupation _____

11. Industry or business Housewife

MOTHER FATHER { 12. Name Andrew Chaney

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

14. Maiden name Nancy Jane Chaney

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

16. (a) Informant Guy Sherard

(b) Address Mayville Missouri

17. (a) Burial (b) Date thereof Sept. 29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woods Cemetery

18. (a) Signature of funeral director Ed Brown

(b) Address Pattersonburg Mo

19. (a) 9-29-44 (b) John Clay
(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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature Ile Harold Fowler (U. or other) do
Address _____ Date signed 9-29-44

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 *E. S. Garner*.....

Licensed Embalmer No. 2887.....

P. O. Address Patonsburg Md.....

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.