

FILED NOV 28 1944
Registration District No. 281946

Primary Registration District No. 2001

Registrar's No. 545

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Freeman Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 6 days (Specify whether years, months or days)
In this community 42 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
(c) City or town Webb City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 201 S. Oronogo 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 4

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11
year 1944 hour 10. minute 20 P.M.
21. I hereby certify that I attended the deceased from 11 5 1944 to 11 11 1944
that I last saw him alive on 11 11 1944
and that death occurred on the date and hour stated above.
Immediate cause of death Lympho sarcoma Duration

3. (a) PRINT FULL NAME John Walter Herrod

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 married

6. (b) Name of husband or wife. Etta Herrod 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased. August 3, 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 8 Days 22 If less than one day -- hr. -- min.

9. Birthplace Nottingham 4 England
(City, town, or county) (State or foreign country)
Grocer

10. Usual occupation Grocer

11. Industry or business Herrod and Son Grocery

12. Name Walter Herrod

13. Birthplace Unknown 4 England
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Taylor

15. Birthplace Unknown 4 England
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Etta Herrod

(b) Address 201 S. Oronogo, Webb City, Mo.

17. (a) Burial (b) Date thereof Nov. 14, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery Carthage Mo.

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage Mo.

19. (a) 11-14-44 (b) Gestus Sushoella
(Date received local registrar) (Registrar's signature)

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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?
(Specify type of place) (e) Means of injury ...
23. Signature J. W. ... (M. D. or other) ...
Address ... Date signed 11/15/44

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

MOTHER FATHER

1204

44-11-947

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: *Ernest L. Stueck*
Licensed Embalmer No. *391*
P. O. Address *Carthage*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Doc

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 545-1

1. PLACE OF DEATH:
 (a) County Jasper
 (b) City or town Joplin
 (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 John W. Hearn
 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 _____
 6. (c) Age of husband or wife if alive _____ year
 7. Birth date of deceased Aug 3 1908
 (Month) (Day) (Year)

8. AGE: Years 62 Months 8 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) _____
 (Date 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 Nov year 1944 hour _____ minute _____ M.

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

Immediate cause of death lymph sarcoma
medullary

Duration _____

Due to _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ signed _____

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

SUPPLEMENTARY

38031