S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1945

Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1

State File No. 5622

Registrar's No. 143

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: 1814 ANGELIQUE (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NONE (Specify whether

In this community 40 YRS. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

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

(d) Street No. 1814 Angelique (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country no

3. (a) PRINT FULL NAME Missouri Ellen Sherls

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex Female

5. Color or race NEGRO

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

6. (b) Name of husband or wife Colman Sherls ~~(Deceased)~~

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

7. Birth date of deceased DECEMBER (Month) 2 (Day) 1862 (Year)

8. AGE:

Years	Months	Days	If less than one day
82	2	11	hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business NONE

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

MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant BEATRICE NORMAN

(b) Address 1814 ANGELIQUE

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB. 17 1945 (Month) (Day) (Year)

(c) Place: burial or cremation SAVANNAH MO.

18. (a) Signature of funeral director Beatrice Gray

(b) Address 819 Pacific St

19. (a) 2-17-45 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13 year 1945 hour 4 minute 55 P. M.

21. I hereby certify that I attended the deceased from 6 Feb, 1945, to 13 Feb, 1945 that I last saw her alive on Feb. 13, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia — Duration 7 day

Due to

Due to 107

Other conditions — (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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 [signature] (M. D. ~~or other~~)

Address St Joseph, Mo Date signed 14 Feb 45

1371 (Licensed Embalmer's Statement on Reverse Side)

MAR 2 1945

MAR 27 1945

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~~ 2/13/45

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Earl a Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph M

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.