

S. No. 2
M-8-43
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **113539**
Registrar's No. **30**

Registration District No. **141** Primary Registration District No. **5551**

1. PLACE OF DEATH:
(a) County **Newell**
(b) City or town **West Plains RFD.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Home Health Care**
(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) **75 yrs.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Newell**
(c) City or town **West Plains**
(If outside city or town limits, write "RURAL")
(d) Street No. **Lebo Road**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Isaac A. Cherry**
(b) If veteran, name war _____ (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 **Mary Jane Cherry** (6) (c) Age of husband or wife if alive **60** years
(7) Birth date of deceased **6-27-85**
(Month) (Day) (Year)

8. AGE: Years **87** Months _____ Days _____ If less than one day _____ min.

9. Birthplace **Jenn Co., Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Geo. Cherry**

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

14. Maiden name **Wick**

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

16. (a) Informant **Geo. Cherry**

(b) Address **West Plains, Mo**

17. (a) _____ **(b) Date thereof** **2/23-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Springfield**

18. (a) Signature of funeral director **Robertson**

(b) Address **West Plains, Mo**

19. (a) **3/3-45** **(b)** _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **2** day **22**
year **1945** hour **11** minute **05 a.m.**
21. I hereby certify that I attended the deceased from **Feb. 19th**
1945 to **Feb. 22nd,** 19 **45**
that I last saw him alive on **Feb. 22nd,** 19 **45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Haemorrhage, left side**
Hemi-plegia, rt.

Due to _____
Due to **Arterio-sclerosis**

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

Major findings: **No operation**
Of operations _____

Of autopsy **none**

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 **Ad. Thornburg** (M. D. or other)
West Plains, Mo Date signed **2/29/45**

Duration **5 da**
Duration **19**
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5

District File Number

Date Filed

445-194
7-12-YS-

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 *D. D. Robertson*

Licensed Embalmer No. *3437*

P. O. Address *Northline, 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.