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M-543  
5-17-39  
I X3687

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29387

State File No. 35

FILED SEP 21 1945  
318

Registration District No. Primary Registration District No. 1003

Registrar's No. 7983

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

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:  
Barnes Hospital, 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hrs.  
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 3970a Finney Ave. 9 11  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Pearl Sherrod

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female 5. Color or race col.

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

6. (b) Name of husband or wife Renie Sherrod

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased 12 24 1895  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 10  
year 1945 hour 5 minute 15 A. M.

21. I hereby certify that I attended the deceased from September 10, 1945 to September 11, 1945  
that I last saw her alive on September 11, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia, left lobe  
hemiplegia

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

40	8	17	hr. min.
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Due to Hydronephrosis + hydronephrosis, right

Due to 101

Other conditions 101  
(Include pregnancy within 3 months of death)

9. Birthplace Ark. - 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Isaac Childress

{ 13. Birthplace Ark. 1  
(City, town, or county) (State or foreign country)

{ 14. Maiden name unknown

{ 15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mattie Leu Wilson

(b) Address 3970a Finney Ave.

17. (a) Parkin, Ark. (b) Date thereof 9-11-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parkin, Ark.

18. (a) Signature of funeral director Allen Dales

(b) Address 3506 Franklin Ave.

19. (a) SEP 12 1945 (b) [Signature]  
(Date received local registry) (Registrar's signature)

PHYSICIAN

Major findings:  
Of operations no operation

Of autopsy as above

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 FR Bradley (M. D. or other).....  
Address Barnes Hospital, Date signed.....

**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.....

.....  
working under my personal supervision.

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

Signed.....

*James A. [Signature]*

..... Licensed Embalmer No. *35722*

..... P. O. Address *3506 Franklin*

**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.**