

S. No. 2  
OM-543  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31966

State File No. \_\_\_\_\_  
Registrar's No. 9124

**FILED** NOV 31 1945

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL," and name of township)  
 (c) Name of hospital or institution:  
De Paul Hospital 0  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Craighead 999  
 (c) City or town..... Jonesboro  
(If outside city or town limits, write "RURAL") N.R. 0  
 (d) Street No.....  
(If rural, give location)  
 (e) Citizen of foreign country?.....  
(Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME Sarah Herrington  
 3. (b) If veteran, name war..... Nil  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20  
 year 1945 hour 6:00 minute A. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced. Widow  
 6. (b) Name of husband or wife.....  
Moses F. Herrington  
 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased. October 7 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-6-45, 19... to 10-20-45, 19...  
 that I last saw her alive on 10-19-45, 19...  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>0</u>	<u>13</u>	hr. _____ min.

Immediate cause of death.....  
Carcinoma of uterus, don't know.

9. Birthplace Craighead - Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Due to.....  
none.

Due to.....

11. Industry or business.....

MOTHER FATHER { 12. Name James Daniels  
 13. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Clarence Gatlin  
 (b) Address 2714 N. 21st St.

17. (a) Removal (b) Date thereof 10-20-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Jonesboro, Arkansas

Major findings:  
 Of operations.....  
 Of autopsy.....

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

18. (a) Signature of funeral director Albert H. Hoppe  
 (b) Address 4700 Washington Blvd.

19. (a) Oct 22 1945 (b) J. F. Brueck  
(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?.....

While at work?.....  
(Specify type of place)  
 (e) Means of injury ☺  
 Address 1506 St. Louis Date signed 10-20-45

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

**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 John Agorowski

Licensed Embalmer No. 2398

P. O. Address.....

**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.**