

STANDARD CERTIFICATE OF DEATH

State File No. **2757**
Registrar's No. **26**

FILED JAN 26 1946
128

Registration District No. _____ Primary Registration District No. **2000**

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Webster** **112**
(c) City or town **Elkland** **0**
(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 _____

3. (a) PRINT FULL NAME **Arthur Sherfield**

3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Bertha Sherfield** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 2, 1885**
(Month) (Day) (Year)

8. AGE: Years **60** Months **9** Days **5** If less than one day _____ hr. _____ min.

9. Birthplace **Chrittenden, Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **On Farm**

MOTHER FATHER { 12. Name **John Sherfield**
13. Birthplace **Unknown Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Lottie Wiley**
15. Birthplace **Unknown Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Bertha Sherfield**
(b) Address **Springfield, Missouri**

17. (a) **Burial** (b) Date thereof **Jan. 7, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Padukah, Kentucky**

18. (a) Signature of funeral director **Alma Lohmeyer Funeral Home**

(b) Address **Springfield, Missouri**

19. (a) **1-8-46** (b) **W. H. Landry**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **7**, year **1946** hour **3** minute **10** P. M.

21. I hereby certify that I attended the deceased from **1/6/1946** to **1/7/1946**

that I last saw h _____ alive on **1/7/1946** and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** **9d.**

Due to **Infection**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 **Henry D. Callaway** (M. D. or other **M.D.**)
Address **Springfield, Missouri** Date signed **1/8/46**

SEP 7 1943

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..... *L. A. Roof*.....

Licensed Embalmer No. *3044*.....

P. O. Address *Springfield Mo*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

X

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(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 Arthur Sherfield

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 _____

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

8. AGE: Years 60 Months 9 Day _____ (Less than one day) hr. _____ 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. (c) 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 _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to Lobar Pneumonia

Due to _____

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

Major findings: Of operations _____

Of autopsy 108

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (c) Means of injury _____

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

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

675

2757