

FILED MAR 27 1946

Registration District No. **32**

Primary Registration District No. **4480**

Registrar's No. **22**

1. PLACE OF DEATH

(a) County **Schuyler**
(b) City or town **Creighton, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **VAN OSDORF HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 weeks**
In this community **most of life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Schuyler**
(c) City or town **Worthington, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

JOHN SHERMAN TERRELL

3. (b) If veteran name and No. **200** 3. (c) Social Security No. **200**

4. Sex **MALE** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W 2**

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

7. Birth date of deceased **June 8 1861**
(Month) (Day) (Year)

8. AGE: Years **84** Months **7** Days **15** If less than one day _____ hr. _____ min.

9. Birthplace **SCOTLAND, Co. MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED FARMER.**

11. Industry or business _____

12. Name **WILLIAM TERRELL**

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

14. Maiden name **EMILY TROTTER**

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

16. (a) Informant **Nelda Dingerich**

(b) Address **Green Top, MO #1.**

17. (a) **Burial** (b) Date thereof **1-28-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Physent Home Cem**

18. (a) Signature of funeral director **D. J. Foster, Son**

(b) Address **Worthington, Mo.**

19. (a) **Feb. 4/46** (b) **Ans. R. Drake**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **23** year **1946** hour **8** minute **10 P.** M.

21. I hereby certify that I attended the deceased from **1** **2**, 19**46** to **1-23**, 19**46** that I last saw him alive on **1-23** and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Prostate** Duration **1 year**

Due to _____

Due to _____

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

Major findings: Of operations **518**

Of autopsy _____

22. If death was due to external causes, fill in the following:
(c) 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 **2**

23. Signature **Carl Van Osdorf** (M.D. or other) _____

Address **Van Osdorf Hospital** Date signed **1-24-46**

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. 10
Embalmer File Number 3-46-548
Date Filed MAR 19 1946

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 F. O. Husted
Licensed Embalmer No. 2975
P. O. Address Unionville Mo

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.