

No. 2
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5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13369**
1908
Registrar's No. **1908**

FILED MAY 6 1948
Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Research Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Weeks**
In this community **5 Years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **17**
(c) City or town **Carrollton**
(If outside city or town limits, write "RURAL")
(d) Street No. **X**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **X**

3. (a) PRINT FULL NAME **Ellis Sherard**

3. (b) If veteran, name war **no.**
3. (c) Social Security No. **512-09-8090**

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

6. (b) Name of husband or wife **Ruth Sherard**
6. (c) Age of husband or wife if alive **39** years

7. Birth date of deceased **August 22 1897**
(Month) (Day) (Year)

8. AGE: Years **48** Months **8** Days **0**
If less than one day hr. min.

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

10. Usual occupation **Marble Cutter**

11. Industry or business **X**

12. Name **Edmond Wells Sherard**

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

14. Maiden name **Lyda Smith**

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

16. (a) Informant **Mrs. Ruth Sherard**

(b) Address **Carrollton, Missouri**

17. (a) **removal** (b) Date thereof **4-23-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Carrollton, Missouri**

18. (a) Signature of funeral director **Stine & McClure,**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **4-24-46** (b) **Edw. H. Adams**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **22**
year **1946** hour minute P. M.

21. I hereby certify that I attended the deceased from **19 April**
1946 to 22 April 19 **46**
that I last saw him alive on **22 April** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Brain Tumor, (Glioma) Malignant** Duration **3 mos?**

Due to.....

Due to.....

Other conditions **5/8**
(Include pregnancy within 3 months of death)

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

Of autopsy **Brain Tumor (Glioma) malignant, Rt. temporal lobe**

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 **Donald F. Coburn** (M. D. or nurse)
Address **1103 Grand Ave. Kansas City, Mo** Date signed **24 April 46**

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

12270

Wm. H. Craft
Teacher
Duff Body

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 W. H. Craft
Licensed Embalmer No. 1415
P. O. Address K. C. 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.