

Registration District No. 374

Primary Registration District No. 4547

Registrar's No. 40

1. PLACE OF DEATH:

(a) County North
(b) City or town Grant city
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 78 yrs (Specify whether years, months or days)
In this community 78 yrs

3. (a) PRINT FULL NAME

John Sherer

3. (b) If veteran name war no

3. (c) Social Security No. no

4. Sex MO 5. Color or race W

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

6. (b) Name of husband or wife Mary Sherer

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Oct. 14 (Month) (Day) (Year)

1865 (Year)

8. AGE: Years 80 Months 11 Days 4 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Ship 1 (State or foreign country)

10. Usual occupation farmer

11. Industry or business

12. Name Michael Sherer 4

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

14. Maiden name Margaret (Unknown)

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

16. (a) Informant Ray Sherer

(b) Address Grant city mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-46 (Month) (Day) (Year)

(c) Place: burial or cremation Ketchikan cem.

18. (a) Signature of funeral director John C. Stuffle

(b) Address Grant city mo.

19. (a) Sept 27-1946 (Date received local registrar) (b) Leta E. Dawson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County North
(c) City or town Grant city (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18 year 1946 hour 11 minute 45 P. M.

21. I hereby certify that I attended the deceased from Sept 1st 1946 to Sept 18 1946 that I last saw him alive on Sept 18 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Intestine Colon Bowels Duration 6 mo
Due to Indurated Imm Pristate 1 yr
gland

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 O. P. Fullerton (M. D. or other)
Address Bedding Linn Date signed 9/20/46

12-21-1921

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Arch C. Dingle*.....
Licensed Embalmer No. *3252*.....
P. O. Address *Leant City, 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.