

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
FILED DEC 9 1946

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

43328

State File No. _____

Registration District No. 364

Primary Registration District No. 4533

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Warne

(b) City or town Wright City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3
(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 Mo (b) County IRON 47

(c) City or town PILLOT KNOB
(If outside city or town limits, write "RURAL")

(d) Street No. 12 (If rural, give location) _____

(e) Citizen of foreign country? ✓ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Lydia Jane Sherrill

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5th.
year 1946 hour 11:30 minute 4 M.

21. I hereby certify that I attended the deceased from Dec 5th
1946, to Dec 5th, 1946;

that I last saw her alive on Dec 5th, 1946;

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

4. Sex F 5. Color or race W.

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

6. (b) Name of husband or wife Andrew Sherrill

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

7. Birth date of deceased March 6 1865
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis and myocardial degeneration - hypert.

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>9</u>	<u>2</u>	<u>hr. - min.</u>

Due to _____

Due to _____

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

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

10. Usual occupation Retired Homekeeper

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

PHYSICIAN

Major findings: 93D

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Herbert Sherrill

(b) Address Wright City Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-10-46
(Month) (Day) (Year)

(c) Place: burial or cremation Pilot Knob Cem

18. (a) Signature of funeral director Neuburg 74 UCo

(b) Address Wright City Mo

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 _____

19. (a) Dec 8-1946 (Date received local registrar) (b) Mrs. F. W. Hughes (Registrar's signature)

23. Signature Raymond A. Foye (M.D. or other) _____
Address Wright City Mo Date signed 12-8-46

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

99

4210

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 12-17-46

DEC 20 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 *Julius J. Neiburg*
Licensed Embalmer No. *3366*
P. O. Address *Wright City M.*

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.