

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1521

FILED FEB 11 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 373

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY OR TOWN KANSAS CITY	c. LENGTH OF STAY (in this place) 18 YRS	c. CITY OR TOWN KANSAS CITY	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 2415 TRACY - C-9		e. STREET ADDRESS (If rural, give location) 41 2415 TRACY - APT C-9	

3. NAME OF DECEASED (Type or Print) CARTER	a. (First) SHERRILL	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 1-21-1954
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5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3-10-1895	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months	IF UNDER 1 HOUR Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (City and State or Foreign Country) ARKANSAS	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME JOHN SHERRILL	13b. MOTHER'S MAIDEN NAME DON'T KNOW	14. NAME OF HUSBAND OR WIFE VERA SHERRILL
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 495-09-1811	17. INFORMANT'S SIGNATURE OR NAME ADDRESS VERA SHERRILL 2415 TRACY K.C. Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of stomach		INTERVAL BETWEEN ONSET AND DEATH 151X
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Anemia DUE TO (c) Cancer cachexia.		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23. SIGNATURE Deputy coroner J.M. Tillman (Degree or title) M.D.	23b. ADDRESS 1618 Lydia Ave	23c. DATE SIGNED 1/21/54
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24a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	24b. DATE 1-23-54	24c. NAME OF CEMETERY OR CREMATORY HIGHLAND	24d. LOCATION (City, town, or county) (State) KANSAS CITY. MO
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DATE REC'D BY LOCAL REG 1-23-54	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BRADY-BROWN K.C. Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John R. Sidman*
Licensed Embalmer No...45
P. O. Address *Kansas*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.