

FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 30329  
883  
Registrar's No. 883

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY OR TOWN Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Burge Hospital		e. STREET ADDRESS (If rural give location) OAK Grove Lane	

3. NAME OF DECEASED (Type or Print) a. (First) Frank	b. (Middle) Leo	c. (Last) Sherman	4. DATE OF DEATH (Month) (Day) (Year) September 20 1954
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED married	8. DATE OF BIRTH Dec. 28, 1903	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (City and State or Foreign Country) Sarcoux, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME George C. Sherman	13b. MOTHER'S MAIDEN NAME Clemma Bathoon	14. NAME OF HUSBAND OR WIFE Florence Sherman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY (If yes, give war or dates of service) 491-05-1628	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Florence Sherman Springfield 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 Hour
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. 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)	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 9-20, 1954 to 9-20, 1954, that I last saw the deceased alive on 9-20, 1954 and that death occurred at 9:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE Kenneth O. Coffey M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 9-20-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 23, 1954	24c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEMETERY	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
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DATE REC'D BY LOCAL REG. 9-21-54	REGISTRAR'S SIGNATURE E. W. Williamson	FUNERAL DIRECTOR'S SIGNATURE J. W. Lengner	ADDRESS Spfld. Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

OCT 1 1933

SEP 27 1933

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 *J. B. K. [unclear]*

Licensed Embalmer No. 335

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.