

FILED JAN 23 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2018

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>15</u>	
1. PLACE OF DEATH a. COUNTY <u>MACION</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>SHELBY</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>FLANNIBAL</u>		c. LENGTH OF STAY (In this place) <u>7 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>HUNNEWELL</u>		d. STREET ADDRESS (If rural, give location) <u>Town Limits</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. ELIZABETH HOSP.</u>				d. STREET ADDRESS (If rural, give location) <u>Town Limits</u>			
3. NAME OF DECEASED (First) <u>GOLDA</u>		b. (Middle) <u>ELLEN</u>		c. (Last) <u>SHERRY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-9-1956</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>9/2/1877</u>	
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>4</u>		IF UNDER 1 YEAR Days <u>7</u>		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>JOHN L. JONES</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET LEARY</u>		14. NAME OF HUSBAND OR WIFE <u>ED SHERRY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>BENTLEY SHERRY</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Thyostatic pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Cerebral hemorrhage, left</u>				<u>11 days</u>	
		DUE TO (c) <u>331X</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Arteriosclerotic heart disease</u>				<u>Several years</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>				20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>—</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>Dec 29, 1955</u> , to <u>Jan 9, 1956</u> , that I last saw the deceased alive on <u>Jan 9, 1956</u> , and that death occurred at <u>10:00 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Charles R. Johnson MD</u>				23b. ADDRESS <u>211 No. Main - Monroe City</u>		23c. DATE SIGNED <u>1-11-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>1/11/1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		24d. LOCATION (City, town, or county) (State) <u>SHELBY CO. MO</u>	
DATE REC'D BY LOCAL REG. <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>Dr. Ed. Lucke By W. Fisher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Rarnes</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JAN 19 1956  
MARION CO. HEALTH DEPT.  
DATE FILED JAN 19 1956

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*Harold T. Garne*

Signed.....  
Student Embalmer

Licensed Embalmer No. 3720

P. O. Address Marion Ct

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.