THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005344
STATE FILE NUMBER

FILED MAR 16 1959 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 23

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) West Plains — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) West Plains Memorial — Length of stay in lb hrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Howell
c. CITY OR TOWN West Plains 0461 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 119 W Cleveland — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Middle Last: George W Cherry
4. DATE OF DEATH Month Day Year: 3-7-1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/5-1882
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR Months 10 Days 2 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hotel Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Excelsior Springs Mo
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: Joe Cherry
13b. MOTHER'S MAIDEN NAME: Mathew Roberts
14. NAME OF HUSBAND OR WIFE: Pearl Cherry
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: yes
17. INFORMANT: Mrs Geo. Cherry — Address: West Plains Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Sclerosis
DUE TO (c) ~~Myocarditis, Chr.~~ Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 332X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1 Mar 59 to 7 Mar 59 and last saw ~~him~~ him alive on 6 Mar 59
Death occurred at 1:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M.D.
22b. ADDRESS: West Plains, Mo
22c. DATE SIGNED: 12 Mar 59

23a. BURIAL, CREMATION, REMOVAL (Specify): B
23b. DATE: 3/8-59
23c. NAME OF CEMETERY OR CREMATORY: Mary Union
23d. LOCATION (City, town, or county) (State): Nocomo Mo

24. FUNERAL DIRECTOR: Robertson — ADDRESS: West Plains Mo
25. DATE RECD. BY LOCAL REG.: 3-13-59
26. REGISTRAR'S SIGNATURE: Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature. All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. 3433

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.