

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009982

STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 167 Primary Registration District No. 4256 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY Johnson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Johnson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Holden		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN 6th and Olive		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 6th & Olive		Length of stay in lb 6 Months	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last David Lee Sheridan			4. DATE OF DEATH Month Day Year March 31, 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1942		9. AGE (In years last birthday) 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Russell Sheridan		13b. MOTHER'S MAIDEN NAME Anita Martin		14. NAME OF HUSBAND OR WIFE	
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. None	17. INFORMANT Address Russell Sheridan Holden, Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary failure					INTERVAL BETWEEN ONSET AND DEATH 3-4 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Sepsis					12 hours
DUE TO (c) Measles					6850
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Progressive Muscular Dystrophy					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 March 27, 1959 , to March 31, 1959 and last saw ^{her} him alive on March 31, 1959 Death occurred at 6:45 pm m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Thomas P. Wescott D.O. 2			22b. ADDRESS Holden, Missouri		22c. DATE SIGNED April 1, 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/2/59	23c. NAME OF CEMETERY OR CREMATORY Shiloh		23d. LOCATION (City, town, or county) (State) Chilhowee, Missouri
24. FUNERAL DIRECTOR Cook Funeral Home		ADDRESS Chilhowee, Mo.		25. DATE RECD. BY LOCAL REG. 4-3-59	26. REGISTRAR'S SIGNATURE Mrs. G. V. Redford

(Licensed Embelmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *J. Cook*
Licensed Embalmer No. *4335*
P. O. Address *Chilhowee*

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.