

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032050

FILED VS OCT 13 1959 / 28

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 1034

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>WEBSTER</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b		c. CITY OR TOWN <u>SEYMOUR</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE HOSP'</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>ROUTE 3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD V. SHERERTZ</u>				4. DATE OF DEATH Month Day Year <u>Oct - 1 - 1959</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-25-1911</u>			
9. AGE (last birthday) <u>43</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>WEBSTER Co. MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>GEORGE SHERERTZ</u>			13b. MOTHER'S MAIDEN NAME <u>SADIE HALE</u>			14. NAME OF HUSBAND OR WIFE <u>HELEN</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>500-01-3492</u>		17. INFORMANT <u>MRS. HELEN SHERERTZ</u>			Address <u>SEYMOUR, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>aneurysm, left middle cerebral artery</u>							DUE TO (c) <u>6 hrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 a.m. p.m.		Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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 <u>6:00</u> <u>10/1/59</u> to <u>10/1/59</u> and last saw him alive on <u>10/1/59</u> Death occurred at _____ P. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>H. McAlhany, M.D.</u> (Degree or title)				22b. ADDRESS <u>401 Prof. Bldg - Springfield, Mo.</u>				22c. DATE SIGNED <u>10/6/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-5-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR MASONIC Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>WEBSTER Co. MO.</u>			
24. FUNERAL DIRECTOR <u>Robert Bergman Seymour, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>10-7-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Meeton</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS OCT 14 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Max J. Miller

Licensed Embalmer No. 4720

P. O. Address Manofield

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.