

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 1 4 1

FILED VS DEC 29 1959

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 6051 Registrar's No. 291

ENDED

1. PLACE OF DEATH a. COUNTY St. Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN South Shore		Length of stay in 1b 1 1/2 years		c. CITY OR TOWN South Shore		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Route #1			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route #1			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Kathlyn Violet Sherman				4. DATE OF DEATH Month Day Year December 1, 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-21-1918	9. AGE (last birthday) 41	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY South Shore Harbor		11. BIRTHPLACE (City and state or country) Denver, Colo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Elmer H. Hoffman		13b. MOTHER'S MAIDEN NAME Grace Parks		14. NAME OF HUSBAND OR WIFE Rayford L. Sherman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 489-18-2566		17. INFORMANT Address Rayford L. Sherman, R#1, South Shore			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart valve lesion (right atrio-ventricular (tricuspid)) which with an acute atypical pneumonia probably gave rise to right heart failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____, to _____ and last saw her/him alive on _____ Death occurred at 3:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) John R. Roberts MD				22b. ADDRESS 100 No Euclid St Louis, Mo.		22c. DATE SIGNED 12/2/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-4-1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION (City, town, or county) St. Ann, Missouri			
24. FUNERAL DIRECTOR 2504		ADDRESS Woodson Rd		25. DATE RECD. BY LOCAL REG. Dec-7-59		26. REGISTRAR'S SIGNATURE Margaret Wilson	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 29 1959

APR 10 1961

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 David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland

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.