

**RRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-016301**

**FILED VS. MAY 9 1960 270**

Registration District No. \_\_\_\_\_ Primary Registration District No. **3050** Registrar's No. \_\_\_\_\_

STATE FILE NUMBER

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Pemiscot</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Caruthersville</b> Length of stay in 1b <b>4 yrs.</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>711 Beckwith Rear</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pemiscot</b> c. CITY OR TOWN <b>Caruthersville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>711 Beckwith Rear</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Robert</b> Middle _____ Last <b>Sherrill</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>22</b> Year <b>1960</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>3/11/94</b>		<b>9. AGE (last birthday)</b> <b>66</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Waldon Ark.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>			
<b>13a. FATHER'S NAME</b> <b>Andy Sherrill</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ara McClellen Sherrill</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War 1</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Ara Sherrill Little Rock, Ark.</b> Address _____					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>This man was found dead in bed.</b> DUE TO (b) <b>Died Without medical attention.</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										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 type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____											
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)				<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.</b> Death occurred at <b>About 10:00 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
<b>22a. SIGNATURE</b> (Degree or title) <i>Jack W Tipton Registrar</i>						<b>22b. ADDRESS</b> <b>810 ward Ave, Caruthersville</b>				<b>22c. DATE SIGNED</b> <b>4/22/60</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>4/26/60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Maple Cemetery</b>				<b>23d. LOCATION</b> (City, town, or county) (State) <b>Caruthersville, Mo.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>H.S. Smith Funeral Home, Caruthersville</b>						<b>25. DATE RECD. BY LOCAL REG.</b> <b>5/2/1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Jack W Tipton</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 11 1960

MAY 18 1960

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.