

REC'D MAY 12 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

14465

Do not use this space.

1. PLACE OF DEATH

(a) County Cape Registration District No. St. Francis Hospital - 121  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3009 Registered No. 15-9  
 (c) City Cape Girardeau (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 646 Sandia Lee Sherill Sikeston, Mo. St.  Sikeston Mo  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Child  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct - 1938  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
- 7 -  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child  
 9. Industry or business in which work was done, as saw mill, bank, etc. Child  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sikeston Mo.  
 FATHER 13. NAME Ralph Sherill  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okla.  
 MOTHER 15. MAIDEN NAME Flossie Collins  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kennett Mo.  
 17. INFORMANT (ADDRESS) Ralph Sherill Sikeston Mo.  
 18. BURIAL, CREMATION, OR REMOVAL Method Park  
 PLACE Sikeston Mo. DATE April 21, 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Arden Ellis Sikeston Mo.  
 20. FILED 4-20-39 7:30 a.m. Compton Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 20, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 4/19, 1939, to 4/20, 1939.  
 I last saw her alive on 4/19, 1939. Death is said to have occurred on the date stated above, at 5:45 am.  
 The principal cause of death and related causes of importance were as follows:  
Laryngeal Diphtheria  
 Date of onset 4/18/39  
 Other contributory causes of importance:  
 Name of operation Autopsy Date of 1939  
 What test confirmed diagnosis? deep Was there an autopsy? No.  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) D. B. Good, M. D.  
 (Address) Cape Girardeau, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECORDING INFORMATION THIS IS A PERMANENT RECORD

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

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 this body is not embalmed, above space should be left blank.**