

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

36843

Do not use this space.

1. PLACE OF DEATH

(a) County Genesee Registration District No. 110
 (b) Township Bragg City Primary Registration District No. 478
 or
 (c) City _____ (d) Street No. _____ St.
 (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
640 Orville Jefferson Sherrill
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8/16/1939
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 6

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. at home
 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) Genesee Co. MO

FATHER
 13. NAME J. J. Sherrill
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Worth Texas

MOTHER
 15. MAIDEN NAME Beylob Null
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laval MO

17. INFORMANT (ADDRESS) J. J. Sherrill Bragg City, MO

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph DATE 10/23 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) _____

20. FILED Nov-9 1939 Miss J. R. Cole Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/22 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-17, 1937, to 10-29, 1939.
 I last saw him 2:00 PM alive on 10-17-39. Death is said to have occurred on the date stated above, at 7:15 AM.
 The principal cause of death and related causes of importance were as follows:

San patient case
in my office
Respiratory Pneumonia
H. M. B.

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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) J. R. Cole M. D.
 (Address) Genesee Co. MO

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

NOV 20 1939

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.