FILED FEB 26 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1346

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 331

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mercy Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 days (Specify whether

In this community 6 months years, months or days)

3. (a) PRINT FULL NAME Dixie Shernaman 655

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced ✓

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased July 9-1939 (Month) (Day) (Year)

8. AGE: Years - Months 6 Days 13 If less than one day hr. min.

9. Birthplace Kansas City Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name John William Shernaman
13. Birthplace Pettis County Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dorothy M Turner
15. Birthplace Kansas City Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. W. Shernaman

(b) Address 1805 Brownell

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23-40 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Mrs. C. L. Forster, K.C.Mo.

(b) Address

19. (a) Jan. 23, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 1805 Brownell (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 22 year 1940 hour 2 minute 40 A.M.

21. I hereby certify that I attended the deceased from 1-20, 1940 to 1-22, 1940 that I last saw her alive on 1-22, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death BRONCHOPNEUMONIA Primary	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work (e) Means of injury

23. Signature Mark S Hogue (M. D. or other)

Address 315 Alameda Rd Date signed 1-22-40

(Licensed Embalmer's Statement on Reverse Side)

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.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I X19511

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address K. C. Mo

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.