

FILED FEB 16 1940 35

Primary Registration District No. 3010

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Carroll  
(b) City or town Carroll  
(c) Name of hospital or institution: State Clinic  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 hrs  
In this community 2 yrs  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll  
(c) City or town Bozard Rural  
(If outside the city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Sally L. Sherwood  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11  
year 1940 hour 2 minute 0 P. M.  
21. I hereby certify that I attended the deceased from Jan 7  
1940 to Jan 11, 1940  
that I last saw her alive on Jan 11, 1940  
and that death occurred on the date and hour stated above.

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife 17 years  
7. Birth date of deceased: Apr. 17 (Month) (Day) (Year) 1935

Immediate cause of death Influenza  
Duration 4 days

8. AGE:	Years	Months	Days	If less than one day
	<u>4</u>	<u>8</u>	<u>24</u>	by _____ min.

Due to \_\_\_\_\_  
Due to 11 P  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Carroll Co. Mo. (City, town, or county) (State or foreign country)  
10. Usual occupation Child

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

11. Industry or business \_\_\_\_\_  
12. Name John Sherwood  
13. Birthplace Carroll Co. Mo. (City, town, or county) (State or foreign country)  
14. Maiden name Heda Ward  
15. Birthplace Arkansas (City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant's own signature John Sherwood  
(b) Address Bozard, Mo. P.F.D.  
17. (a) Burial (b) Date thereof 1-13-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Beatty Cem  
18. (a) Signature of funeral director St. Paul  
(b) Address Carroll Co. Mo.  
19. (a) 1-13-40 (b) John Haskins  
(Date received local registrar) (Registrar's signature)

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)  
23. While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature J. R. Hamilton \_\_\_\_\_ D. or other) \_\_\_\_\_  
Address Carroll Co. Mo. Date signed Jan 11 1940

WHILE FILLING IN THIS CERTIFICATE OF DEATH, PLEASE PRINT CLEARLY AND IN INK—MAKE A PERMANENT RECORD

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.

FILED  
District File Number  
OFFICE HEALTH OFFICER No. 8,  
07/27/40

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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.**