

AUG 23 1940  
Registration District No. 200

Primary Registration District No. 5553B

State File No.

Registrar's No. 146

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson Mo  
(c) Name of hospital or institution: Jackson Co Home  
(d) Length of stay: In hospital or institution 3 yrs  
In this community 155 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 1707 Paradise Way  
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19  
year 1940 hour 4 minute 40 AM.  
21. I hereby certify that I attended the deceased from March 15 - 1940 to July 19 1940  
that I last saw him alive on July 19 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of uterus  
Due to  
Due to  
Other conditions  
Major findings: Of operations  
Of autopsy

Duration  
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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
23. Signature W. Booker (M. D. or other)  
Address 2028 Vine Date signed 7/23/40

3. (a) PRINT FULL NAME LOVIE SHERMAN

3. (b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex. Fe  
5. Color or race Negro  
6. (a) Single, widowed, married, divorced, widowed

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

7. Birth date of deceased: Nov 15 1890  
(Month) (Day) (Year)

8. AGE: Years 49 50 Months 8 Days 4  
If less than one day hr. min.

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

10. Usual occupation Home duties

11. Industry or business Home

12. Name Mr. Patterson  
18. Birthplace South Knoxville  
(City, town, or county) (State or foreign country)

14. Maiden name  
15. Birthplace  
(City, town, or county) (State or foreign country)

16. (a) Informant Steve Thompson  
(b) Address 1910 Montgall KC Mo

17. (a) Burial (b) Date thereof 7-26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation  
18. (a) Signature of funeral director

(b) Address 1819 E 15th KC Mo  
19. (a) 7-25-40 (b) J. G. [Signature]  
(Date received local registrar) (Registrar's signature)

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

**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 Edw H Edwards

Licensed Embalmer No. 3836

P.O. Address 1819 E 1st St Kansas

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **25369**  
Registrar's No. **146**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **400**

Primary Registration District No. **833318**

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

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Prairie**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME **Lovie Sherman**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased **Nov 15 1890**  
(Month) (Day) (Year)

8. AGE: Years **49** Months **8** Days **4** If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **9-6-40** (b) **Sara S. James**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH Month **July** day **19**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **R. A. Booker** (M. D. or other) \_\_\_\_\_  
Address **2028 Vine St** Date signed \_\_\_\_\_  
**K.C. Mo**

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

SUPPLEMENTARY

