

No. 2
4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

38730

State File No. _____

Register District No. 318

Primary Registration District No. 2001

Registrar's No. 938

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

PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: Burge Hospital
(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 Ruby Katherine Sherrow

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife J. A. Sherrow

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

7. Birth date of deceased November 9, 1891
(Month) (Day) (Year)

8. AGE: Years 49 Months 0 Days 13 hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business In Home

12. Name Charles E. Maple

13. Birthplace Stockholm, Sweden
(City, town, or county) (State or foreign country)

14. Maiden name Audley Bergman

15. Birthplace Stockholm, Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant J. A. Sherrow

(b) Address Route 2, Springfield, Mo.

17. (a) Burial (b) Date thereof 11-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director Wm. G. Johnson

(b) Address Springfield, Mo.

19. (a) 11-25-40 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. Route 2
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22
year 1940 hour 11:30 minute 9 M.

21. I hereby certify that I attended the deceased from September 11, 1940
_____, 19____, to November 22, 1940
that I last saw her alive on November 22, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Mal-nutrition

Dehydration 6 mo.

Anemia, hypochromic 4 mo.

Post-operative shock adenoma

Due to Pseudo mucinous cyst adenoma 6 mo.
which had extended to the peritoneum

Other conditions malignant termination primary seat
(Include pregnancy within 3 months of death) ovary

PHYSICIAN

Major findings: Pseudo mucinous cyst adenoma
Of operations which had extended to the peritoneum

Of autopsy malignant termination
No. autopsy

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? no

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

23. Signature Leola R. Webb (M. D. or other) _____
Address Springfield - 240 Date signed 11-23-40

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.....

Harlow Knab

Licensed Embalmer No. *4065*

P. O. Address *Springfield W*

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, fact should be so stated above.