

Registration District No. 20

Primary Registration District No. 1001

Registrar's No. 555

1. PLACE OF DEATH:

(a) County BUCHANAN  
(b) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 601-DEWEY-AVE.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 1 WEEK. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County GENTRY  
(c) City or town STANSBERRY  
(If outside city or town limits, write "RURAL")  
(d) Street No. P7 D#2 (If rural, give location)  
(e) If foreign born, how long in U. S. A. 1 years.

3. (a) PRINT FULL NAME ANDREW JACKSON SHERRY

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

4. Sex Male 5. Color Wh 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife Rose Meads 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased March 1 1878 (Month) (Day) (Year)

8. AGE: 63 Years 2 Months 24 Days If less than one day hr. min.

9. Birthplace Gentry County, MO (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

MOTHER FATHER

12. Name Low Sherry

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

14. Maiden name Low Sherry

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

16. (a) Informant Virgil D. Sherry

(b) Address 2723 1st Joe ave

17. (a) burial (b) Date thereof May 26 1941 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cem.

18. (a) Signature of funeral director Ray Clancy

(b) Address St Joseph MO

19. (a) May 26 1941 (Date received local registrar) (b) Virgil D. Sherry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1941 hour 11:30 minute a M.

21. I hereby certify that I attended the deceased from May 20 1941, to May 25 1941; that I last saw him alive on May 23 1941; and that death occurred on the date and hour stated above.

Immediate cause of death myocardial Failure!

Due to Generalized arterosclerosis

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? 85  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Joyce L. Roentgen (M. D. or other) MD.  
Address Kirkpatrick Alder Date signed 5/26/41

Duration 1 week  
PHYSICIAN —  
Underline the cause to which death should be charged statistically.

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

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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.....

*May 25*  
working under my personal supervision.

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

Signed

*John H. Hurley*

Licensed Embalmer No. *4050*

P. O. Address *St. Joseph Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19609

Registration District No. 86

Primary Registration District No. 1001

Registrar's No. 533

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(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 Andrew Jackson Sherry  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
63 2 24 hr. 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 25 -  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration \_\_\_\_\_

Due to Generalized arteriosclerosis

Due to Myocarditis

Other conditions (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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?

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

23. Signature Irwin D. Rosenthal (M.D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

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