

FILED MAY 15 1944

Registration District No. 376

Primary Registration District No. 4462-6074 Registrar's No. 38.1.23

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Flat River, Rural  
(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 \_\_\_\_\_  
In this community 2 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois  
(c) City or town Rural  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jessie Sherrill

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

4. Sex Male 5. Color or race White 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 Sept. 15 1860  
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 11  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

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

MOTHER FATHER { 12. Name Wesley Sherrill  
13. Birthplace Reynolds Co. Missouri  
14. Maiden name Martha Alcorn  
15. Birthplace Reynolds Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Archie Sherrill  
(b) Address Elvins, Missouri

17. (a) Burial (b) Date thereof 4/30/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Glover, Missouri

18. (a) Signature of funeral director Sparks Und. Co.

(b) Address Flat River, Missouri

19. (a) 5-2-44 (b) J. J. Johnson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1944 hour 5:50 minute A.M.

21. I hereby certify that I attended the deceased from 3-26-44 to 4-22-44 that I last saw him alive on 4-22-44 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration \_\_\_\_\_  
Atherosclerosis

Due to Senility

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

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

Major findings: 9321  
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? \_\_\_\_\_  
(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 D. B. Johnson (M. D. or other) \_\_\_\_\_

Address Flat River, Mo. Date signed 4/29/44

RECEIVED 5-13-44

District Health Officer No. 4

District File Number 544-38

Date Filed 5-13-44

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 *Beverly Sparks*

Licensed Embalmer No. 4287

P. O. Address Flat River

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.

Registration District No. 316

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH

(a) County St. Francois  
(b) City or town Elving P. Hubert Rural  
(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..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

Jessie Sherill

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

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

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

7. Birth date of deceased Sept 15 (Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 15 (Unless 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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)..... (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) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6 year 1944 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....; that I 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..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

156916