

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

773

FILED JAN 31 1945  
318

State File No. \_\_\_\_\_  
Registrar's No. 687

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days 0  
(Specify whether \_\_\_\_\_)

In this community 21 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Duo

(c) City or town St Louis 17  
(If outside city or town limits, write "RURAL")

(d) Street No. 1325 N 24th St 219  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Tom Sherrod

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

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Maggie Sherrod 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased April 13, 1885.  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 21  
year 1945 hour 5 minute 25 AM

21. I hereby certify that I attended the deceased from January 6, 1945 to January 21, 1945  
that I last saw him im alive on January 21, 1945  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>9</u>	<u>8</u>	hr. _____ min. _____

Immediate cause of death Chr Nephritis with Renal Failure Unk

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

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

Other conditions (Include pregnancy within 3 months of death) 12/1

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

10. Usual occupation Nil.

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

MOTHER FATHER

12. Name Robert Sherrod

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

14. Maiden name Fannie Anderson.

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Maggie Sherrod

(b) Address 1325 N. 24 th St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24, 1945. (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Wright's Funeral Home.

(b) Address 3100 Easton Ave.

19. (a) JAN 23 1945 (Date received local registrar) (b) J. F. Bredeck (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? \_\_\_\_\_

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

(c) Means of injury \_\_\_\_\_

23. Signature Alva Moore (M. D. or other) \_\_\_\_\_

Address 2601 N. Whitten St. Date signed 1-22-45

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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.....

*Arthur L. Hilliard*

Licensed Embalmer No.....

*4221*

P. O. Address.....

*1154 Bayard*

**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.**