V. S. No. 2
0M—8-43
ev. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1945

Registration District No. 217

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5787

State File No. 6685

Registrar's No. 7

1. PLACE OF DEATH:

(a) County: Mississippi

(b) City or town: Charleston (rural) Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R#3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 8 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Miss.

(c) City or town: Charleston (rural)
(If outside city or town limits, write "RURAL")

(d) Street No.: R#3
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country: None

3. (a) PRINT FULL NAME: Crawford Sherrod

3. (b) If veteran, name war: ----

3. (c) Social Security No.: ----

4. Sex: M

5. Color or race: Colored

6. (a) Single, widowed, married, divorced: N.K.

6. (b) Name of husband or wife:

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

7. Birth date of deceased: December (Month) 3rd (Day) 1882 (Year)

8. AGE: Years 62 | Months 1 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace: Covington (City, town, or county) Tenn (State or foreign country)

10. Usual occupation: Farming

11. Industry or business:

FATHER
12. Name: Samuel Sherrod
13. Birthplace: Fate Co. (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name: Maria Sanford
15. Birthplace: Covington, Tenn, (City, town, or county) (State or foreign country)

16. (a) Informant: Needham Sherrod
(b) Address: R#3 Charleston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Grove Charleston, Mo.

18. (a) Signature of funeral director: Chas F Nunnelee
(b) Address: Charleston Mo

19. (a) 1/15/45 (Date received local registrar) (b) Mrs Lon Mace (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 12th year 1945 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec 24, 1944 to Jan 12, 1945 that I last saw him alive on Jan 11, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Pyelonephritis — Duration: 6 mo.

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations: None
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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: A. P. Fenton M.D. (M.D. or other)
Address: Wyatt, Mo. Date signed: 1-18-45

1257

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 245-218
Date Filed 2-15-45

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 John T. Nunnelee Jr

Licensed Embalmer No. 3851

P. O. Address Charleston Mo

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.