

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

36551

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 85

Registration District No. 13 Primary Registration District No. 5059

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

1. PLACE OF DEATH:

(a) County Barry

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

(c) Name of hospital or institution:
R.F.D. # 2 Aurora Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community _____ years, months or days) (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry

(c) City or town Rural Ozark Twship
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. # 2 Aurora Mo.
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Josephine Sherrick

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

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, 2 divorced, Widowed

6. (b) Name of husband or wife J.D. Sherrick 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 20 1862
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 23
year 1945 hour 4 minute 00 A.M.

21. I hereby certify that I attended the deceased from July 30 1944 to October 22 1945
that I last saw h. or alive on October 1945
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>3</u>	<u>3</u>	hr. _____ min. _____

Immediate cause of death Chronic Myocarditis Duration 6 months

Due to _____

Due to _____

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

9. Birthplace ? Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name W.J. Knox

13. Birthplace ? N, Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Mary Mysinger

15. Birthplace ? N, Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Pearl Akin
(b) Address R 2 Aurora Mo.

17. (a) Burial (b) Date thereof 10/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Aurora Mo

18. (a) Signature of funeral director J.F. King
(b) Address Aurora Mo.

19. (a) 10-27-45 (b) W.M. West
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations None

Of autopsy None

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) (c) Means of injury _____

23. Signature Ernest H. Kelley M.D. Date signed 10/27/45
Address Aurora Mo.

MOTHER FATHER

RECEIVED

District Health Officer No. 6;

District File Number 1143-1114

Date Filed NOV 17 1945

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..... *Herman Lurridge*

Licensed Embalmer No. 3072

P. O. Address Aurora 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.