

No. 2
M-5-43
5-17-39
I X36671

FILED JAN 7 1947
Registration District No. 117

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jacks on

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

(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hrs. (Specify whether years, months or days) as above

3. (a) PRINT FULL NAME Baby Sherrill

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced, infant

6. (b) Name of husband or wife X

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

7. Birth date of deceased December 24 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

- - - 4 hr. min.

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

10. Usual occupation infant

11. Industry or business X

MOTHER FATHER

12. Name Elmo T. Sherrill

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

14. Maiden name Geraldine Grant

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

16. (a) Informant Elmo T. Sherrill

(b) Address 1503 E. 35th St., K. C., Mo.

17. (a) burial (b) Date thereof 12-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH, CEM.

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 12-27-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1503 East 35th St.,
(If rural, give location) no.

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 24
year 1946 hour 10:00 minute 0 M.

21. I hereby certify that I attended the deceased from 6 hr
12/24 1946 to 10:00 1946
that I last saw her alive on 12/24 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital absence of kidney

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 157 hr

Major findings: _____

Of operations _____

Of autopsy yes

Duration _____

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 H. V. Hallberg (M. D. or other) _____
Address 231 - W - 42th Date signed 12/26

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

281 W
47 St.

Dr. Hallberg

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..... Robert H. Reed.....
Licensed Embalmer No. 3745.....
P. O. Address..... 1pc. 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.