

FILED JUN 3 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18654

State File No. 4678

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>STONE NURSING HOME</u>				d. STREET ADDRESS (If rural, give location) <u>5758 Waterman Ave.,</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>DUSTIN</u>		b. (Middle) <u>LAWRENCE</u>		c. (Last) <u>SHERRILL.</u>	
		4. DATE OF DEATH		(Month) <u>May</u>		(Day) <u>26</u> (Year) <u>1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>April 18, 1864</u>		9. AGE (In years last birthday) <u>86</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 14 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired; Wholesale</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mens Furnishings.</u>		11. BIRTHPLACE (State or foreign country) <u>Concordia, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert Hardin Sherrill.</u>		13b. MOTHER'S MAIDEN NAME <u>Anne Milicia Popham.</u>		14. NAME OF HUSBAND OR WIFE <u>Katherine Stroud Sherrill.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lawrence C. Sherrill; 17 Southmoor Dr.,</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Occult Carcinoma of the prostate</u> <u>Right bundle branch block indicating grave myocardial pathology.</u>  ANTECEDENT CAUSES <u>Chronic myocarditis</u>  Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <u>Chronic myocarditis</u>  DUE TO (c) <u>Age and carcinoma of the prostate</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>177X</u>			
22. I hereby certify that I attended the deceased from <u>May 12</u> , 19 <u>50</u> , to <u>May 26</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>50</u> , and that death occurred at <u>4:30 A.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Katherine Stroud Sherrill M.D.</u>				23b. ADDRESS <u>607 No. Grand Blvd</u>		23c. DATE SIGNED <u>May 26, 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/29/1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>MAY 27 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Karater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C.R. Lupton &amp; Sons; 7233 Delmar Blvd.</u>			

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

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, 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.