

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 8 - 1956

STATE FILE NUMBER
67

Registration District No. 360 Primary Registration District No. 6225 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Winnon</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Newton Co</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Washington</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>Seneca 0730</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL (OR) INSTITUTION <i>DeWald State Hosp</i> Length of stay in 1b <i>17-8-27</i>		d. STREET ADDRESS (If outside, give location) <i>Rt 1</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Richard Leneed Sherer</i> First Middle Last			4. DATE OF DEATH <i>8-2-1956</i> Month Day Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-11-1912</i>
9. AGE (In years last birthday) <i>44</i>		IF UNDER 1 YEAR Months <i>9</i> Days <i>21</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>C C Camp</i>	11. BIRTHPLACE (City and state or country) <i>Missouri</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Edward Sherer</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Scott</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Adm. papers -</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Vessel Disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>atherosclerotic sclerosis</i> DUE TO (c) <i>Pulmonary Tuberculosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7/2</i> <i>7/2</i> <i>7/4</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <i>Dementia Precox - Smith 420.1A</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I for Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <i>4-23-53</i> to <i>8-2-56</i> and last saw her alive on <i>8-1-56</i> Death occurred at <i>11 AM</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Edwin Dickins MD</i>		22b. ADDRESS <i>Newton Mo</i>	22c. DATE SIGNED <i>8-2-56</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>8-3-56</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Seneca Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Seneca, Missouri</i>
24. FUNERAL DIRECTOR <i>Biddlecome, Funeral Home, Seneca, Mo</i>	ADDRESS	25. DATE REC'D. BY LOCAL REG. <i>8-3-1956</i>	26. REGISTRAR'S SIGNATURE <i>Anna E. Ferry</i>

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1-56

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.....
Signature of Student Embalmer

Signed.....
Rory F. Milster

Licensed Embalmer No. 480

P. O. Address.....
Nevada

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.