

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020061
STATE FILE NUMBER

8
MAY 25 1959

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 84

300
1-57

| | | | | | |
|---|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Saline | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Grand Pass | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Fitzgibbon hosp. | | Length of stay in lb 4 days | d. STREET ADDRESS Streets not numbered | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) George Calender Sherman | | | 4. DATE OF DEATH May 19th 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 11th 1876 | | 9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor | | 10b. KIND OF BUSINESS OR INDUSTRY General store | 11. BIRTHPLACE (City and state or country) Mt. Crawford Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13a. FATHER'S NAME George Franklin Sherman | | 13b. MOTHER'S MAIDEN NAME Mary Elizabeth Hahn | | 14. NAME OF HUSBAND OR WIFE ----- | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 495-36-7439 | 17. INFORMANT Address Francis Sherman, Carrollton Mo. R.F.D. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) fractured rt hip DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days 1 wk |
| 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 or 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 097 | | COUNTY STATE | |
| 21. I attended the deceased from 5.14.59 to 5.19.59 and last saw ^{her} him alive on 5.18.59 Death occurred at 1:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE W. N. [Signature] | | (Degree or title) M.D. | | 22b. ADDRESS Marshall Mo | |
| 22c. DATE SIGNED 5/19/59 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 21, 1959 | | 23c. NAME OF CEMETERY OR CREMATORY Slater City cemetery | |
| 23d. LOCATION (City, town, or county) Slater Missouri | | | | | |
| 24. FUNERAL DIRECTOR Campbell-Lewis, Marshall Mo. | | 25. DATE RECD. BY LOCAL REG. 5-20-59 | | 26. REGISTRAR'S SIGNATURE Cecil G. Read | |

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 *R.W. Campbell*.....

Licensed Embalmer No. *3469*.....

P. O. Address *Marshall*.....

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.