

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1960

-60-040661

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 3095

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>St. Louis.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Reynolds</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lemay, Mo.</b>		c. CITY OR TOWN <b>Lesterville</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mt. St. Rose Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Rural Route</b>	

3. NAME OF DECEASED (Type or print) First <b>Elvis</b> Middle <b>Preston</b> Last <b>Sherrill</b>			4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/3/1895</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Red Cap Terminal</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.R. Union Station</b>		11. BIRTHPLACE (City and state or country) <b>Flat River, Mo.</b>	
13a. FATHER'S NAME <b>Edward Sherrill</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Alcorn</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>Yes W.W.#1</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Frances LaBrot, Ironton, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>1. Far advanced bilateral fibro-caseous Pulmonary Tuberculosis</b>	<b>Over 1 yr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <del>Pyogenic lung abscess, left upper lobe</del>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pyogenic lung abscess, left upper lobe</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 or PART II of item 18.)
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year	

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 <b>Ironton, Mo.</b>	COUNTY <b>Reynolds</b>	STATE <b>Missouri</b>
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21. I attended the deceased from **March 12 thru Oct. 23, 1960** and last saw her **10-23-60**  
Death occurred at **7:00 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>David M. Skilling Jr. M.D.</b>	22b. ADDRESS <b>18 S. Kingshighway</b>	22c. DATE SIGNED <b>10-25-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-27-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Ironton, Mo.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc.,</b>	ADDRESS <b>4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>10-25-60</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS NOV 3 1960

JAN 10 1961

MS DEC 9 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. Courrier, Rm

Licensed Embalmer No. 42

P. O. Address H. Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.