

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-049958

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11443**

FILED JAN 6 1966			
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Mo.</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION P.D.#1 St Louis City Hospital</p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Mo. b. COUNTY St Francois</p> <p>c. CITY OR TOWN Flat River Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 102 Juniper Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		
<p>3. NAME OF DECEASED First Middle Last (Type or print) Harold Ray Sherrill</p>			
<p>4. DATE OF DEATH Month Day Year 11-29-1965</p>			
<p>5. SEX Male</p>	<p>6. COLOR OR RACE White</p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 6-16-1931</p>
<p>9. AGE (last birthday) 34</p>		<p>IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Construction</p>	
<p>11. BIRTHPLACE (City and state or country) Hogan, Missouri</p>		<p>12. CITIZEN OF WHAT COUNTRY USA</p>	
<p>13a. FATHER'S NAME Elize Sherrill</p>		<p>13b. MOTHER'S MAIDEN NAME Clara Swearingin</p>	
<p>14. NAME OF HUSBAND OR WIFE Glenda Sherrill</p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No</p>	
<p>16. SOCIAL SECURITY NO. Unk.</p>		<p>17. INFORMANT Address Glenda Sherrill (See #2)</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>			
<p style="text-align: center;">IMMEDIATE CAUSE (a) Intra-cerebral Hemorrhage due to Trauma with Cerebral Contusions and Edema; Suffered when I beam collapsed pinning deceased head between brine tank & roof at Velvet Freeze Dairy 3230 Gravois Ave., on November 29th, 1965 at about 9:17 A.M.</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Accident</p>			
<p>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 910306</p>			
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>		<p>20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour Month, Day, Year 9:17 a.m. 11-29-65</p>			
<p>20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Factory</p>	
<p>20f. CITY, TOWN, OR LOCATION St. Louis, Missouri</p>		<p>COUNTY STATE</p>	
<p>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 9:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE (Degree or title) Helen L. Taylor, Coroner</p>		<p>22b. ADDRESS 1300 Clark Ave.</p>	
<p>22c. DATE SIGNED 11-30-65</p>		<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Removal</p>	
<p>23b. DATE 11-30-1965</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery</p>	
<p>23d. LOCATION (City, town, or county) (State) Leadinton, Mo.</p>		<p>24. FUNERAL DIRECTOR ADDRESS Caldwell Funeral Home Flat River, Mo.</p>	
<p>25. DATE RECD. BY LOCAL REG. NOV 30 1965</p>		<p>26. REGISTRAR'S SIGNATURE Road Smith, H.D.</p>	

AMENDED

DO NOT WRITE ON THIS STUB

VS 300 Rev. 4/59

1

2 0926

3

4 0

5 1

6

7 0

8 1

9

10

11 000

12 02-3

13

91

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

2-24-68
0-0-1
1
170
C-50

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 James Pearson

Licensed Embalmer No. 5168

P. O. Address Millfield Rd

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.