

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Scott
Township _____
or _____
Village Drehtstot
or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 818 File No. 28647
Primary Registration District No. 4494 Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Don Sharp

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Dec 18, 1898</u> (Month) (Day) (Year)		
AGE <u>34 yrs. 6 mos. 18 ds.</u>		IF LESS than 1 day, ___ hrs., or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>General Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>3-07</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Tinonville Ill</u>		
PARENTS	NAME OF FATHER <u>Joseph Sharp</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>	
	MAIDEN NAME OF MOTHER <u>Raisa Harmon</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tinonville Ill</u>	

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
July 1, 1933
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 20, 1933, to July 1, 1933, that I last saw him alive on July 1, 1933, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Paemia
115 B
36 (Duration) yrs. mos. 7 ds.
Contributory Submaxillary abscess
(SECONDARY) (Duration) yrs. mos. 10 ds.
(Signed) W. Smith M. D.
July 2, 1933 (Address) Drehtstot Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted
If not at place of death? _____
Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Etta Welch
(ADDRESS) Drehtstot Mo
Filed Aug 15, 1933 W. Smith
REGISTRAR

PLACE OF BURIAL OR REMOVAL
Magnad cemetery
UNDERTAKE
Irvin & Co
DATE OF BURIAL
July 2, 1933
ADDRESS
Drehtstot Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Labprer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH
 County Scott
 Township
 or
 Village Niehlstadt
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 818 File No. _____
 Primary Registration District No. 4494 Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lon Sharp

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>M.</u>	COLOR OR RACE <u>W.</u>	MARITAL STATUS <u>married</u> <small>(Write the word)</small>	DATE OF DEATH <u>July 1, 1913</u> <small>(Month) (Day) (Year)</small>	
DATE OF BIRTH <u>Satisfactory Information Supplied.</u>			I HEREBY CERTIFY, that I attended deceased from _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____.	
AGE <u>Satisfactory Information Supplied.</u>			THE CAUSE OF DEATH was as follows: <u>Pyemia (Cryptogenic) probably due to the infection of glaucoma in eye.</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			Duration) yrs. mos. ds. <u>7</u>	
BIRTHPLACE (City or town, State or foreign country) _____			Contributory <u>Sub maxillary abscess.</u> <small>(SECONDARY)</small> Duration) yrs. mos. ds. <u>10</u>	
PARENTS	NAME OF FATHER _____		(Signed) <u>R. Smith</u> M. D. <u>July 2, 1913</u> (Address) <u>Niehlstadt</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	MAIDEN NAME OF MOTHER _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		At place of death yrs. mos. ds. In the State yrs. mos. ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Satisfactory Information Supplied.</u>			Where was disease contracted if not at place of death? _____	
(ADDRESS) _____			Former or usual residence _____	
Filed <u>Aug 15</u> 191 <u>3</u> <u>R. Smith</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Satisfactory Information Supplied.</u>	
			DATE OF BURIAL _____ 191____	
			UNDERTAKER _____	

SUPPLEMENTARY
 Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
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