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

Do not use this space.

File No. 419
Registered No. 306

1. PLACE OF DEATH
County: Cape
Registration District No.: 125
Township:
Primary Registration District No.: 2099
City: Cape Girardeau St. Francis Hosp. St. Ward)

2. FULL NAME: Alvin Paul Sharp
(a) Residence. No. St., Ward. Jackson, Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Mar. 21, 1918.

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
11	10	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Wayne Co
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Frank Sharp
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Petaly
(STATE OR COUNTRY): Ill
12. MAIDEN NAME OF MOTHER: Margaret Shipton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Wayne Co
(STATE OR COUNTRY): Mo.

14. INFORMANT: Margaret Sharp.
(Address): Jackson Mo.

15. FILED 1/28 1930 Eve Kempfer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 27 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930, to Jan 27, 1930 that I last saw h/m alive on Jan 27, 1930 and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis (Hx General) 212 M
129 (duration) 5 yrs. mos. 2 ds.
CONTRIBUTORY (SECONDARY) Rupture of Jejunum (Traumatic) (duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED: Illmo Mo
IF NOT AT PLACE OF DEATH —
DID AN OPERATION PRECEDE DEATH? No DATE OF 1-27-30
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) [illegible], M. D.
, 19 (Address) Cape Girardeau

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Lorimer Cemetery Mo. DATE OF BURIAL: 1/29 1930
20. UNDERTAKER: Burpling Koff & Hubbard ADDRESS: Illmo Mo.

AUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Cape Girardeau Registration District No. 125 File No.
Township Primary Registration District No. 3009 Registered No. 306
City (No. St. Ward)

2. FULL NAME Alvin Paul Sharp
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 3/14/ 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1930

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Peritonitis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Rupture of Vesuvius
Traumatic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Boy was injured while coasting
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [signature] , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE [illegible] AS PRESCRIBED BY LAW

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