

REC'D JUN 9 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

17446

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 2143
 (c) City Kansas City (d) Street No. 5850 Brookside Blvd. St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mrs. Margaret Sharpe 610
 (a) Residence, No. 5850 Brookside Blvd. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Derby Sharpe</u>			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>November 9, 1891</u>			
7. AGE YEARS <u>46</u>	MONTHS <u>6</u>	DAYS <u>14</u>	If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
9. Industry or business in which work was done, as saw mill, bank, etc. <u>At home in</u>			
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>California</u>			
13. NAME <u>Jefferson D. Conner</u>			
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>			
15. MAIDEN NAME <u>Minnie Strett</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>			
17. INFORMANT <u>Derby Sharpe (Husband)</u> (ADDRESS) <u>5850 Brookside Blvd, Kansas City</u>			
18. BURIAL, CREMATION, OR DEPOSITORY <u>Mt. Moriah Cem</u> PLACE <u>Kansas City, Missouri</u> May 25 1938			
19. FUNERAL DIRECTOR <u>Stine & McClure</u> (ADDRESS) <u>3235 Gillham Pla</u>			
20. FILED <u>May 24, 1938</u> <u>M. M. Korone</u> Local Registrar.			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23, 193822. I HEREBY CERTIFY, That I attended deceased from 5-21, 1938, to 5-23, 1938I last saw h. a. n. alive on 5-23, 1938. Death is saidto have occurred on the date stated above, at _____ P. _____ m. 2:45

The principal cause of death and related causes of importance were as follows:

Carcinoma of the breast with metastasis

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____Where did injury occur? _____
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) George V. Feid, M. D.(Address) 806 professional

1-5 pm
V.I. Schmitt

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed

..... Licensed Embalmer No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. 1744638

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2143

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY <u>Jackson</u>	b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>	a. STATE	b. COUNTY
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN	
		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Margaret</u>	b. (Middle) <u>Conner</u>	c. (Last) <u>Sharpe</u>	(Month) <u>May</u>	(Day) <u>23</u>	(Year) <u>1938</u>
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH		9. AGE (In years last birthday)
				IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	ANTECEDENT CAUSES		
	DUE TO (b) <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reinterment</u>	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY <u>Dallas, Texas</u>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <u>5-24-38</u>	REGISTRAR'S SIGNATURE <u>M. M. Crowe</u>	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
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SUPPLEMENTARY

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Heraldine Holmsted
(Licensed Embalmer's Statement on Reverse Side)

303

1938
S-17446

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
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, fact should be so stated above.