

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED JUN 10 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17351

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2013

2008

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: General Hospital # 205
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 50 yrs
years, months or days

3. (a) PRINT FULL NAME ACIE SHARP

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 2. Color or race negro

5. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: 3 (Month) - 4 (Day) - 1873 (Year)

8. AGE: Years 68 Months 2 Days 13 hr. _____ min. _____

9. Birthplace Dalton, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business _____

12. Name John Sharp

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Nona Sharp

(b) Address 10 N. James St, K.C. Kan.

17. (a) Burial (b) Date thereof 5-23-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bluebird Lawn

18. (a) Signature of funeral director [Signature]

(b) Address 1811 E. 12th St, K.C. Mo.

19. (a) May 22, 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 926 Nero
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day 5-16-41 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 3:00 P. to _____ 19 _____ that I last saw him/her _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death: Unresolved lobar pneumonia
(it lower) & multiple pulmonary abscesses

Due to _____

Due to _____

Other conditions 100%
(Include pregnancy within 3 months of death)

Major findings: 100%
Of operations _____

Of autopsy Yes

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

Means of injury 3

23. Signature [Signature] (M. D. or other) _____
Address K. P. No. Date signed _____

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.....

....., Registered Apprentice No.....

..... working under my personal supervision.

Signed

E. Steubing Bull

Licensed Embalmer No. *03178*

P. O. Address *1811 E. 12th K.C.*

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.