

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 44

FILED APR 23 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 1001

Registrar's No. 387

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 7 yrs (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1008 So 11<sup>th</sup>  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Margaret Sharp

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed  
6. (b) Name of husband or wife I.R. Sharp 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased November 23 1853  
(Month) (Day) (Year)

8. AGE: Years 88 Months 4 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name W.M. Carter  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Jane Forsyth  
15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Paul Townsend  
(b) Address St Joseph, Mo.

17. (a) Burial (b) Date thereof 4 13 42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Balckow, Mo.

18. (a) Signature of funeral director Fleming & Son Inc  
(b) Address St Joseph, Mo.

19. (a) 4-11-42 (b) Rae Henry  
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11  
year 1942 hour 6 minute 45 P.M.

21. I hereby certify that I viewed the deceased on  
April 11 1942  
that I last saw her alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 1 day  
Due to Angina Pectoris 1 yr

Due to 94a

Other conditions (Include pregnancy within 3 months of death)  
Woman died suddenly after  
Major findings: several attacks of  
acute indigestion, pains in  
Of autopsy no I her left chest  
and digginess

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) (e) Means of injury \_\_\_\_\_

23. Signature H F Mundy (M. D. or other) Coroner  
Address 404 So 2d St Date signed 4/11/42

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

011  
1  
7

101 S 15A

**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, ~~only~~.....  
..... Registered Apprentice No.....  
working under my personal supervision.\*

Signed *Robert D. Gable*

Licensed Embalmer No. *3308*

P. O. Address *1*.....

**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.**