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V. S. No. 2
00M—2-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

27077

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

FILED AUG 23 1943

State File No. 7408

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Days (Specify whether
In this community
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:** 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 921
(If outside city or town limits, write "RURAL")

(d) Street No. 1800 Cole Street.,
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME John Henderson Sharp

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White 0

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased September (Month) 23 (Day) 1857 (Year)

8. AGE: Years 85 Months 10 Days 21 If less than one day hr. min.

9. Birthplace Fredericktown (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER
12. Name William Sharp
13. Birthplace Fredericktown (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Mary Burks
15. Birthplace Unknown (City, town, or county) Tennessee 1 (State or foreign country)

16. (a) Informant Mrs. McKay

(b) Address 1800 Cole Street.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/43 (Month) (Day) (Year)

(c) Place: burial or cremation Fredericktown, Missouri

18. (a) Signature of funeral director Albert H. Hoppe, Inc

(b) Address 4700 Washington Blvd.,

19. (a) ~~8-14-43~~ (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 14. year 1943 hour 8:00 minute A. M.

21. I hereby certify that I attended the deceased from August 5. 1943 to August 14. 1943 that I last saw him alive on August 14. 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) Senility

Major findings:
Of operations

Of autopsy Not done

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Frank Steinberg (M. D. or other) M.D.

Address 1515 Lafayette Avenue, Date signed 8/14/43

(Licensed Embalmer's Statement on Reverse Side)

7408

7408

## 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.....

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.**