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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 5 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

441516

State File No. _____
Registrar's No. 1367

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County... BUCHANAN
(b) City or town... ST. JOSEPH
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... 18 hr.
In this community...
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State... MO (b) County... DE KALB
(c) City or town... MAYSVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME... MARY GERTRUDE SHARP
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 16 year 1943 hour 8:30 minute P.M.
21. I hereby certify that I attended the deceased from Dec 15 1943 to Dec 16 1943 that I last saw her alive on Dec 16 1943 and that death occurred on the date and hour stated above.

4. Sex... FEMALE
5. Color or race... W
6. (a) Single, widowed, married, divorced... W
6. (c) Age of husband or wife if alive... 27 years
7. Birth date of deceased... Nov 27 1875
(Month) (Day) (Year)

Immediate cause of death... Fibillation of heart
Due to... ch Nephritis
Duration... 2 1/2 hrs
6 hrs

8. AGE: Years 68 Months 0 Days 19
If less than one day hr. min.

Due to...
Other conditions...
(Include pregnancy within 3 months of death)
Major findings:
Of operations...
Of autopsy...
1318

9. Birthplace... FAIRPORT MO
(City, town, or county) (State or foreign country)
10. Usual occupation... AT HOME

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

11. Industry or business...
12. Name... JOHN B ROBINSON
13. Birthplace... IRELAND
(City, town, or county) (State or foreign country)
14. Maiden name... MARGARET GAULT
15. Birthplace... MO
(City, town, or county) (State or foreign country)

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. W. Kearney (M. D. certifying)
Address... St Joseph Mo Date signed 12-16-43

16. (a) Informant... Clifford Robinson
(b) Address... Maysville Mo
17. (a) (b) Date thereof... 12-16-43
(Month) (Day) (Year)
(c) Place: burial or cremation... Fairport Mo
18. (a) Signature of funeral director... F. W. HOPKINS
(b) Address... Maysville MO
19. (a) 12-16-43 (b) R. H. Hagan
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

MAR 29 1944

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.....

L. Fisher
Licensed Embalmer No. 3969

P. O. Address.....
Marysville, Me.

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.