

S. No. 300
DM-10-47
Rev. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29959**
Registrar's No. **3861**

FILED OCT 1 1948
Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 hour
(Specify whether)

In this community 40 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**

(c) City or town Kansas City
(If outside city or town limits, write "RURAL") **5**

(d) Street No. 1621 East 22 Street
(If rural, give location) **5**

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

If yes, name country _____

3. (a) PRINT FULL NAME Delce William Sharp

3. (b) If veteran, name war no

3. (c) Social Security No. 495-09-9642

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18
year 1948 hour 2 minute 10 P. M.

21. I hereby certify that I attended the deceased from Deputy 19__ to Coroner 19__;

that I last saw him alive on _____ 19__;

and that death occurred on the date and hour stated above.

4. Sex male 2

5. Color or race negro

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

6. (b) Name of husband or wife Laura Sharp

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased: June 1 1883
(Month) (Day) (Year)

Immediate cause of death: Cardiac Failure

Due to Coxsackia of head

Due to acute Duodenal Obstruction

Other conditions (include pregnancy within 3 months of death) 46%

Major findings: Of operations _____

Of autopsy Same as above

8. AGE: Years Months Days If less than one day

65 3 21 hr. min.

9. Birthplace: Unknown Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation Hedcarrier

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Robert Sharp

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

14. Maiden name Mary Mitchell

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

16. (a) Informant Laura Sharp

(b) Address 1621 East 22 Street

17. (a) Burial (b) Date thereof 9/21/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln

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 RD

23. Signature W. J. Williams (M. D. or other) MD

Address 2636 - Brooklyn Date signed _____

18. (a) Signature of funeral director Watkins Bros

(b) Address 1729 2nd St

19. (a) 9-21-48 (b) Estherline Holmes
(Date received local registrar) (Registrar's signature)

9-21-48

W. J. Williams

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 *J. Manlove*.....

Licensed Embalmer No. *3994*.....

P. O. Address *2503 Highland*.....

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.