U.S. No. 300
Rev. 10.48

FILED DEC 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40907

BIRTH NO. _____ REG. DIST. NO. 132 PRIMARY REG. DIST. NO. 4203 Registrar's No. 15 1

40 0 0

1. PLACE OF DEATH
a. COUNTY: Grundy
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Galt 1
c. LENGTH OF STAY (in this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Mo
b. COUNTY: Grundy Mo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Galt 0
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): WESLEY
c. (Last): SHARP

4. DATE OF DEATH (Month) (Day) (Year): 11-5-49

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced
8. DATE OF BIRTH: 4-17-1884
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months 6, Days 18 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: Retired farmer
11. BIRTHPLACE (State or foreign country): Sullivan Co Mo 0
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: John W Sharp
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: ✓

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ✓
17. INFORMANT'S SIGNATURE OR NAME: Leland Sharp — **ADDRESS**: Spickard Mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. — 331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-1-, 1949, *to* 11-5-, 1949, *that I last saw the deceased alive on* 11-3-, 1949, *and that death occurred at* 11:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): U. C. Weston MD
23b. ADDRESS: Galt, Mo
23c. DATE SIGNED: 11-6-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-8-49
24c. NAME OF CEMETERY OR CREMATORY: Humphreys Cemetery
24d. LOCATION (City, town, or county) (State): Humphreys Mo

DATE REC'D BY LOCAL REG.: 11-8-49
REGISTRAR'S SIGNATURE: Irene Barr
25. FUNERAL DIRECTOR'S SIGNATURE: PK Paynton — **ADDRESS**: Galt Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
DEC 12 1949
DISTRICT
HEALTH OFFICE
CAMERON, MO.

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 ....., Student Embalmer No. ....., working under my personal supervision.

Student .....
Student Embalmer

Signed P. K. Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.