

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **9481**

FILED APR 6 1953

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **327**

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield 8396	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 916 Woodlawn	
d. FULL NAME OF HOSPITAL OR INSTITUTION 916 Woodlawn			
3. NAME OF DECEASED (Type or Print) a. (First) SAMUEL b. (Middle) CHARLES c. (Last) SHARMAN			4. DATE OF DEATH (Month) (Day) (Year) March 28 1953
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11 April 1885
9. AGE (in years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Sta. Oper.	11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Sharman	
13b. MOTHER'S MAIDEN NAME Matilda Crocker		14. NAME OF HUSBAND OR WIFE Elola Sharman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT'S SIGNATURE OR NAME Vernon Sharman		ADDRESS Springfield, 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, asthma, etc. It means the disease, injury, or complication which caused death.			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Uremia			INTERVAL BETWEEN ONSET AND DEATH 10 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerotic Cardio Muscular Disease			10 yrs
DUE TO (c) Cerebral Accident			8 yrs or 2 weeks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4221	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1946 , to Mar 28, 1953 , that I last saw the deceased alive on _____, 19____, and that death occurred at 2:45 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS 609 Cherry Springfield	
23c. DATE SIGNED 30 Mar 53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-30-53	
24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield Mo.	
DATE REC'D BY LOCAL REG. 3-30-53		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE J.W. KLINGNER & CO.		ADDRESS Springfield, 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 *Ogle Stone Jr* _____

Licensed Embalmer No. *4176* _____

P. O. Address *Springfield* _____

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.