

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18633**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **588**

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Infirmary</b>		e. STREET ADDRESS (If rural, give location) <b>1610 N. Campbell</b> <b>6296</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>LON</b>	b. (Middle)	c. (Last) <b>SHARP</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 21, 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 4, 1869</b>	9. AGE (In years last birthday) <b>85</b>	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 YEAR Hours	13. UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Health Dept.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Health Comm.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Texas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William Sharp</b>	13b. MOTHER'S MAIDEN NAME <b>Caroline Crow</b>	14. NAME OF HUSBAND OR WIFE <b>Margaret Sharp</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Margaret Sharp Springfield, Mo.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Cardiovascular Disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic Peritubular Nephritis 1952</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4/22/1</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **March, 1946**, to **June 21, 1954**, that I last saw the deceased alive on **June 20, 1954**, and that death occurred at **7:15 P.M.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>J. Newton Wollerman M.D.</b>	23b. ADDRESS <b>Springfield Mo</b>	23c. DATE SIGNED <b>6/22/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6-23-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Maple Park Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>6-23-54</b>	REGISTRAR'S SIGNATURE <b>Edith Williamson</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J.W. Klingner &amp; Co. Spfld. Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....  
Signature of Student Embalmer

Signed.....  
*Max Rod*

Licensed Embalmer No. *40*

P. O. Address.....  
*Spring*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.