

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010420  
STATE FILE NUMBER

FILED APR 8 1958

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 65

300  
-57  
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1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u> <u>0493</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Carthage</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McCune Brooks Hosp.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>1239 James</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lacie</u> Middle <u>Ellen</u> Last <u>Sharp</u>			4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1869</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Carthage, Mo.</u> <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Thomas Knight</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca Carnahan</u>	14. NAME OF HUSBAND OR WIFE <u>W. H. Sharp</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>W. H. Sharp</u> Address <u>1239 James, Carthage, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia, both lower lob.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	490X
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Carthage, Missouri</u>	COUNTY _____ STATE _____
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21. I attended the deceased from <u>Mar. 21, 1958</u> to <u>March 21, 58</u> and last saw her alive on <u>March 21, 1958</u> Death occurred at <u>4:30</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Shovel J. Patterson, M.D.</u>	22b. ADDRESS <u>Carthage, Missouri</u>	22c. DATE SIGNED <u>3-24-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>3-24-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dudman Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jasper Co., Missouri</u>
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24. FUNERAL DIRECTOR <u>Ulmer Funeral Home, Carthage, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-24-58</u>	26. REGISTRAR'S SIGNATURE <u>W. H. Clinton</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Edwin S. [Signature]* .....

Licensed Embalmer No. *4955* .....  
P. O. Address *[Signature]* .....

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.