

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018494

STATE FILE NUMBER

2307

FILED MAY 23 1958

Registration District No. 149

Primary Registration District No. 1007

Registrar's No.

300
1-57 4

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| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2102 LINWOOD BLVD. LINMONT NURSING HOME | | Length of stay in 1b 84 YEARS | d. STREET ADDRESS (If outside, give location) 4144 MCGEE STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First MINERVA Middle JANE Last SHARP | | | 4. DATE OF DEATH Month MAY Day 3 Year 1958 | | |
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| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT-6-1869 | 9. AGE (In years last birthday) 88 | 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) RETIRED BOOKKEEPER | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) QUINCY ILLINOIS | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME SAMUEL SHARP | 13b. MOTHER'S MAIDEN NAME SARAH FERGUSON | 14. NAME OF HUSBAND OR WIFE |
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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) No | 16. SOCIAL SECURITY NO. - | 17. INFORMANT SAMUEL C. SHARP Address 4144 MCGEE STREET KANSAS CITY MO |
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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) CORONARY THROMBOSIS | | INTERVAL BETWEEN ONSET AND DEATH 4 HRS. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) CORONARY ARTERIO SCLEROSIS | | 10 YRS? |
| | DUE TO (c) GENERALIZED ARTERIO SCLEROSIS | | 10 YRS? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC CARDIAC DECOMPENSATION | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input 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 _____ a.m. _____ p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ |
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| 21. I attended the deceased from 3-20-1957 to 5-3-58 and last saw her alive on 5-3-58 Death occurred at 5-3-58 1:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE [Signature] (Degree or title) | 22b. ADDRESS 46209 Nicholas Hwy, #515, MO | 22c. DATE SIGNED 5-4-58 |
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|------------------------------------------------------------|---------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE MAY 6, 1958 | 23c. NAME OF CEMETERY OR CREMATOR FOREST HILL Cem | 23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI |
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| 24. FUNERAL DIRECTOR DW. NEWCOMER'S SONS ADDRESS 1391 BRUSH CREEK KANSAS CITY MO. | 25. DATE RECD. BY LOCAL REG. 5-6-58 | 26. REGISTRAR'S SIGNATURE [Signature] |
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

L. M. Field

MEDICAL CERTIFICATION



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 *Vern Lawler*

Licensed Embalmer No. *4915*
P. O. Address *K.C. MO*

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.