

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044859

STATE FILE NUMBER

DEC 17 1958

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 121

1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Macon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Macon</u> <u>06110</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>702 Pearl</u>		Length of stay in lb <u>1/13.</u>		d. STREET ADDRESS (If outside, give location) <u>702 Pearl</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Emmett</u> Last <u>Sharp</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</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>Apr. 14, 1873</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Goods</u>		11. BIRTHPLACE (City and state or country) <u>College Mound, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Richard Sharp</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Dysart</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Jennie Sharp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT <u>Dr. C.E. Sharp</u> Address <u>Callao, Mo.</u>			
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>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						4201F	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Debility following hip fracture</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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.)				
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
21. I attended the deceased from <u>26 Nov 58</u> to <u>26 Nov 58</u> and last saw him alive on <u>26 Nov 58</u> Death occurred at <u>26 Nov 8:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Donald E Eggleston M.D.</u>		22b. ADDRESS <u>Macon, Missouri</u>		22c. DATE SIGNED <u>3 Dec 58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 29, 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Macon Mo.</u>		
24. FUNERAL DIRECTOR <u>Lester Sutton</u>		ADDRESS <u>Macon, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12/16/58</u>		26. REGISTRAR'S SIGNATURE <u>Ruth McNeely</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DEC 17 1958

JAN 9 1959

County File No. 12-58-181  
Date Filed 12-15-58

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 *Charles L. Hutton*

Licensed Embalmer No. *4577*

P. O. Address *Macon, 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.