

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031587

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 167 Primary Registration District No. 5594 Registrar's No. 111

STATE FILE NUMBER

FILED SEP 4 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>JEFFERSON</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural - Meramec 12/10th 60</u> Length of stay in lb <u>12/10th 60</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hill Infirmary</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>MO</u> b. COUNTY <u>JEFFERSON</u></p> <p>c. CITY OR TOWN <u>House Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>R.O.D.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First <u>MARTIN</u> Middle <u>J.</u> Last <u>SCHARP</u></p>	
<p>4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1962</u></p>	
<p>5. SEX <u>M</u></p>	<p>6. COLOR OR RACE <u>W</u></p>
<p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>10/8/1866</u></p>
<p>9. AGE (last birthday) <u>95</u></p>	<p>IF UNDER 1 YEAR Months Days Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Zimmer</u></p>
<p>11. BIRTHPLACE (City and state or country) <u>House Springs Jefferson Co. U.S.A.</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	
<p>13a. FATHER'S NAME <u>Charles Scharp</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Mary Hauser</u></p>
<p>14. NAME OF HUSBAND OR WIFE <u>Single</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u></p>	
<p>16. SOCIAL SECURITY NO. <u>None</u></p>	
<p>17. INFORMANT <u>Bro. Koch - St. Joseph's Hill Infirmary</u> Address <u>Eureka</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis c Cerebral</u></p> <p>DUE TO (c) <u>and Cardiovascular involvement</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.</p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>1960</u> to <u>8/20/1962</u> and last saw him alive on <u>8/16/1962</u>. Death occurred at <u>1.30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>Patrick C. Hogan M.D.</u></p>	<p>22b. ADDRESS <u>3654 South Grand St. Louis 18</u></p>
<p>22c. DATE SIGNED <u>8/20/62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>8/24/62</u></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <u>St. Martin's Cem</u></p>	
<p>23d. LOCATION (City, town, or county) (State) <u>High Ridge MO</u></p>	
<p>24. FUNERAL DIRECTOR <u>Reimmer Funeral Home</u> ADDRESS <u>House Springs MO</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>8-24-62</u></p>
<p>26. REGISTRAR'S SIGNATURE <u>Robert E. Bauer</u></p>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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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 Herbert J. Lee Jr

Licensed Embalmer No. 4800

P. O. Address Likewood 22 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.