AUG 16 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

21138

1. PLACE OF DEATH

County Greene Registration District No. 318 File No.

Township Springfield Primary Registration District No. 7001 Registered No. 417

City Springfield (No. Springfield Baptist Hospital St. Ward)

2. FULL NAME Josephine Sharp

(a) Residence. No. Fair Grove Mo. R#3. St. Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3. SEX: Female — 4. COLOR OR RACE: white — 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married	16. DATE OF DEATH (month, day and year) July 4 1927
5a. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF W.H. Sharp	17. I HEREBY CERTIFY, That I attended deceased from July 3, 1927, to July 4, 1927 that I last saw her alive on July 4, 1927, and that death occurred, on the date stated above, at 8 P.M. m.
6. DATE OF BIRTH (month, day and year) June 25-1877	THE CAUSE OF DEATH* WAS AS FOLLOWS: 129B General Peritonitis 129B 129 (duration) yrs. mos. 2 ds.
7. AGE: Years 50, Months 0, Days 9. If LESS than 1 day, ... hrs. or ... min.	CONTRIBUTORY (SECONDARY) Intestinal obstruction (Loop of ileum) (duration) yrs. mos. 3 ds.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work House wife (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Fair Grove Mo
9. BIRTHPLACE (city or town) (State or country) Wis	Did an operation precede death? yes Date of July 3-27
10. NAME OF FATHER Wm. J. Hotelling	Was there an autopsy? No
11. BIRTHPLACE OF FATHER (city or town) (State or country) Wis-	What test confirmed diagnosis?
12. MAIDEN NAME OF MOTHER Hattie Tory	(Signed) Walling Smith, M.D. 7-5, 1927 (Address) Springfield Mo.
13. BIRTHPLACE OF MOTHER (city or town) (State or country) Wis	*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal.
14. INFORMANT W.H. Sharp. (Address) Fair Grove, Mo.	19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Comfort Cemty — DATE OF BURIAL Jan 7 1927
15. Filed 7/5, 1927 O C Horst M.D. Registrar	20. UNDERTAKER J. W. Klingner & Co — ADDRESS 404 E. ... St. Springfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1178

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. ....

Township .... Primary Registration District No. 2001 Registered No. 417

City Springfield (No. .... St. .... Ward)

2. FULL NAME Sephine Sharp

(a) Residence. No. .... St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	M

5A. If Married, Widowed, or Divorced HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .... (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT .... (Address)

15. FILED 7/5 1927 O C Horst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4 1927

17. I HEREBY CERTIFY, That I attended deceased from ...., 19.... to ...., 19....

that I last saw h.... alive on ...., 19...., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis

Appendiceal Abscess

........(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Intestinal Obstruction

........(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ....

DID AN OPERATION PRECEDE DEATH? .... DATE OF ....

WAS THERE AN AUTOPSY? ....

WHAT TEST CONFIRMED DIAGNOSIS? ....

(Signed) ...., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-21138