LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH
County: Greene
Township: ..... or
Village: ..... or
City: Springfield Mo. (No. 647 Pearl St.; 1st Ward)

Registration District No.: 318
Primary Registration District No.: 2001

File No.: 39195
Registered No.: 857

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME: Essie L. Sharp

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: May 5th, 1888 (Month) (Day) (Year)

7 AGE: 30 yrs. 6 mos. 14 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Domestic 11A
(b) General nature of industry business, or establishment in which employed (or employer): 108

9 BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS
10 NAME OF FATHER: Jackson West
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
12 MAIDEN NAME OF MOTHER: Nancy Kilburn
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Sallie Phillips
(Address): 647 Pearl St. Springfield, Mo.

15 Filed: NOV 20 1918 (191..) Edwin F. James, Registrar
Dollie B. Johnson, Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 19th, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 1, 1918, to Nov 18, 1918, that I last saw her alive on Nov 18, 1918, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:
Influenza +
10
Unresolved Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Russell M. D.
11/19, 1918 (Address) Springfield Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Green Lawn — DATE OF BURIAL: 11-20th, 1918
20 UNDERTAKER: Carson Und. Co — ADDRESS: 410 South St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ...St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191..... (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....,

that I last saw h.....alive on....., 191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
20 UNDERTAKER	**ADDRESS**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.