1928

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

Do not use this space.

36472

1. PLACE OF DEATH

County: Franklin — Registration District No. 796

Township: — Primary Registration District No. 4180

City: Union (No. ..., ... St. ..... Ward)

File No. ..... Registered No. .....

2. FULL NAME: J. R. 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: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR): do not know

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
about	80			

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): Do not know

PARENTS

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Do not know

14. INFORMANT: Wm. Dreas
(Address): Union, Mo.

15. FILED: Dec 22 1927 — Ca Stumpmyer, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 21 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1927, to Dec. 21, 1927, that I last saw him alive on Dec. 21, 1927, and that death occurred, on the date stated above, at 10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis chronic
18 C 4
N. 194 C
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY): Fractured Femur
(duration) ... yrs. ... mos. ... ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF: —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

Dec 22, 1927 (Signed) W. S. Dewoodward, M. D.
(Address) St. Clair Mo.

*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: New Haven Cemetery, New Haven, Mo. — DATE OF BURIAL: Dec 23 1927

20. UNDERTAKER: G. H. Otto — ADDRESS: Washington Mo.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin — Registration District No. 296 — File No. .....

Township ..... — Primary Registration District No. 4180 — Registered No. .....

City Union (No. ....., ... St. ..... Ward)

2. FULL NAME J. R. 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)
M	W	W

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 ....., 19..... E. A. Sturbuger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 21 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:
Myocarditis Chronic
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fractured femur
Fell on concrete steps at country
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED Infirmary in Union Mo

IF NOT AT PLACE OF DEATH? .....

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

WAS THERE AN AUTOPSY? 185

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

SUPPLEMENTARY

5-36472