MAY 25 1929

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

Do not use this space.

14508

1. PLACE OF DEATH

County Howell — Registration District No. 383 — File No. .....

Township Goldsberry — Primary Registration District No. 5534 — Registered No. 12

City Mtn View Mo (No. ..... St. ..... Ward)

2. FULL NAME Frank S. 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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(or) WIFE OF~~ Amanda S. Sharp

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-26-1851

7. AGE: 77 Years — 3 Months — 27 Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(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) Illinois

PARENTS

10. NAME OF FATHER Joe Sharp

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

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Not Known

14. INFORMANT Joe Sharp (Address) Chilhowee Mo.

15. FILED 5-9, 1929 G F Goo REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 17 1929

17. I HEREBY CERTIFY, That I attended deceased from 4-14, 1929, to 4-17, 1929, that I last saw him alive on 4-17, 1929, and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

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

CONTRIBUTORY (SECONDARY) 1010 (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) T. C. Ferrell, M.D.

, 19 (Address) Mtn View, 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: Chilhowee Mo. — DATE OF BURIAL: 4/20 1929

20. UNDERTAKER: J F Duncan — ADDRESS: Mtn View Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.