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

Do not use this space.

16004

File No. 4026

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. Missouri Baptist Hosp St. ..... Ward)

2. FULL NAME Mildred Sharpe

(a) Residence. No. 1502 Mississippi Ave St., 73 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Wife of Eugene Sharpe.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 5. 1906.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
22.	5.	28.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clothes Presser
(b) General nature of industry, business, or establishment in which employed (or employer) Dress Factory.
(c) Name of employer

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

PARENTS

10. NAME OF FATHER James W. Blackman

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

12. MAIDEN NAME OF MOTHER Florence Shelby.

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

14. INFORMANT Eugene Sharpe
(Address) 1502 Mississippi ave.

15. FILED ..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 3. 1929

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 2.30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic cardiac valvular disease
Mitral regurgitation
GSA
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) NA
(duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Samuel B. Grant, M. D

April 4, 1929 (Address) 3720 Washington

*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
Charleston Mo.	April 5 1929.

20. UNDERTAKER Allen H. McLaughlin — ADDRESS 1631 Gravois