

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

Do not use this space.

37275

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 330 Grand ave)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 4745
St. _____ Ward _____

2. FULL NAME

Wanda Louise Sharp
(a) Residence. No. 3602 Tilden Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 14 - 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
3 9 4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Fort Robinson
(STATE OR COUNTRY) Nebr.

10. NAME OF FATHER Elmer L. Sharp

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

12. MAIDEN NAME OF MOTHER Bertha Ellison

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

14. INFORMANT Elmer L. Sharp
(Address) 3602 Tilden Leeds m

15. FILED 11/19 1929 M.M. Crowe REGISTRAR
ans

MEDICAL CERTIFICATE OF DEATH

21 Monday
16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 18 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 10:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental Fract skull -
2.00.15 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) fall in elevator shaft of K.C. Light Plant
(duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTO. SYM? No

WHAT TEST CONFIRMED DIAGNOSIS? History & Inspection
(Signed) Arthur M. Hall M. D.
11/18 1929 (Address) Kepcity Crowe

*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 Brookings, O. DATE OF BURIAL Nov. 20 1929

20. UNDERTAKER Keylar Funeral Home - K. C. Mo
ADDRESS _____

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.

