

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

Do not use this space.

38942

241

PLACE OF DEATH

County Dallas

Registration District No. 241

Township Buffalo

Primary Registration District No. 4147

City Buffalo (No.)

File No.

Registered No. 570

St. Ward

2. FULL NAME

Rachel A. Sharp

(a) Residence. No. Buffalo St. 5th Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF James R. Sharp

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-28-59

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>70</u>		<u>9</u>	<u>4</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Harrison Co. Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Eleven Ward

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

12. MAIDEN NAME OF MOTHER Garrison

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

14. INFORMANT Dr. B. F. Johnson (Address)

15. FILED 1/10 1931 Harvey Morn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/19 1930

17. I HEREBY CERTIFY That I attended deceased from Dec-10 1930 to Dec-14 1930 that I last saw her alive on Dec-14 1930 and that death occurred, on the date stated above, at 11:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Back acted off
Pneumonia

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH. DATE OF

19. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS (Signed) B. F. Johnson, 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 Olive Cemetery DATE OF BURIAL 12/20 1930
20. UNDERTAKER A. S. Sogard ADDRESS Buffalo Mo

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.

JAN 19 1931

71-8-21

to SOA
for 1975

1975
1975

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