

No. 2
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5-17-39
P 1 X2142

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Dr J.R.McDaniel
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42415

State File No.

JAN 13 1940

Registration District No. 247

Primary Registration District No. 5405

Registrar's No.

5
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Rives
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 3 Days (Specify whether
years, months or days) 2

3. (a) PRINT FULL NAME Charles W. Sharp

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 30 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Rives Mo
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER { 12. Name W.L. Sharp
13. Birthplace Flatwood Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Linnie Bon
15. Birthplace Newport Ark
(City, town, or county) (State or foreign country)

16. (a) Informant W.L. Sharp
(b) Address Rives, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12, 3, 40.
(Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion Cemetery

18. (a) Signature of funeral director J.L. German

(b) Address Steele, Mo.

19. (a) 12-8-40 (Date received local registrar) (b) E. D. Cape (Registrar's signature) 2/60

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Rives, Mo. (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 2nd
year 1940 hour Six minute _____ PM.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pressure from delivery
We think

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 160 lb

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J.R. McDaniel (M. D. or other) _____
Address Steele Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No.

District File Number 141-2

Date Filed 1/9/41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed, by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.