

1. PLACE OF DEATH: TEXAS 12 mi. S. of
 (a) County TEXAS
 (b) City or town CAHOON
 (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 39 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County TEXAS 107
 (c) City or town 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.

3. (a) PRINT FULL NAME MARY A SHARP
 3. (b) If veteran, name was Civil War Widow
 3. (c) Social Security No. Civil War Pension

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 18
 year 1941 hour 11:20 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.

4. Sex FEMALE 5. Color of race WHITE
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife George Sharp 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 25 1894
 (Month) (Day) (Year)

Immediate cause of death Cerebral
La Grippe
 Due to _____
 Due to _____

8. AGE: Years 86 Months 8 Days 25 If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations Decom - the affl. death never saw before
 Of autopsy _____
 Duration _____

9. Birthplace Wright Co. Mo (City, town, or county) (State or foreign country)
 10. Usual occupation HOUSE KEEPER

11. Industry or business _____
 12. Name Thomas Pointer
 13. Birthplace Indian (City, town, or county) (State or foreign country)
 14. Maiden name Nancy Gilmore
 15. Birthplace Indian (City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Charley Mitchell
 (b) Address Carroll Mo
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19-41 (Month) (Day) (Year)
 (c) Place: burial or cremation St. Pauls
 18. (a) Signature of funeral director Earl Bell
 (b) Address Carroll Mo
 19. (a) Jan 19 1941 (Date received local registrar) (b) Mrs. Chris Cunningham (Registrar's signature)

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?
 23. Signature E. J. Russell (Specify place) (City or town) (County) (State)
 Address Carroll Mo signed _____

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

7000

RECEIVED

District Health Officer No. 5,

District File Number 241161

Date Filed _____

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.