

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

Do not use this space.

DEC 17 1941

39190

1. PLACE OF DEATH

County Ralls

Registration District No. 726

Township Spencer

Primary Registration District No. 4432

City Wichita, Mo.

File No. 01

Registered No. 30

St. Mo.

Ward 11

2. FULL NAME

Joon Ann Sharick

(a) Residence. No. 1

St. Mo.

Ward. 11

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

yrs. mos. ds.

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)

July 25, 1941

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

8

18

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Perth-Ambury, N.Y.

PARENTS

10. NAME OF FATHER

John Sharick

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Europe

12. MAIDEN NAME OF MOTHER

Marie DeMarco

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Perth Ambury, New Jersey

14. INFORMANT

(Address)

Marie Sharick

Perth Ambury, N.Y.

15. FILED

11/14

1941

Blanche Megowan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Nov 13

1941

17.

I HEREBY CERTIFY, That I attended deceased from

0

1941, to

0

1941

that I last saw him alive on

0

1941, and that

death occurred, on the date stated above, at

12:15

PM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sudden Death

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(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 AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

None

(Signed)

H. A. Waters

M. D.

11-13, 1941 (Address)

New London, Mo.

*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

Barkley Cemetery

Nov 15, 41

20. UNDERTAKER

James O'Donnell

ADDRESS

New London, Mo.

2022 -

N. B.—Every item of information 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.

RECEIVED

District Health Officer No. 10

District File Number

12-41-2197

Date Filed

DEC 15 1941

ABIL

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39190

Registration District No. 226

Primary Registration District No. 4432

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Ruffs
(b) City or town New London
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ years, months or days)

3. (a) PRINT FULL NAME

Jean A. Sharick

3. (b) If veteran

name war _____

3. (c) Social Security

No. _____

4. Sex

M

5. Color or race

W

6. (a) Single, widowed, married, divorced

S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

Feb. 25, 1948
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

hrs min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write "RURAL")

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH

Month

Day

year

hour

minute

M.

21. I hereby certify that I attended the deceased from

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

Immediate cause of death _____

Duration _____

Due to Baby brought to my office after death & have no way of knowing cause

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

H. P. Waters

(M. D. or other)

Address

New London, Mo

Date signed

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

SUPPLEMENTARY

S-39190