

FILED MAR 10 1942

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

8177

Do not use this space 113

1. PLACE OF DEATH

(a) County Woods Registration District No. 9-0-3
 (b) Township Allen Primary Registration District No. 11-110 Registered No. 0
 or Denver (c) City mo (d) Street No. 1 St. 0
 (e) Length of residence in city or town where death occurred _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

RACHELA SHARP d
 (a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed 2
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE Joseph Sharp
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 5 - 1883
 7. AGE YEARS 78 MONTHS 9 DAYS 8 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Homemaker
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana 1

FATHER 13. NAME Henry Spain

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky 1

MOTHER 15. MAIDEN NAME Basheba Brown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana 1

17. INFORMANT Walter Sharp (ADDRESS) Denver mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Kent Cemetery DATE Jan 14 1942

19. FUNERAL DIRECTOR (NAME) W. Brown Bros (ADDRESS) Denver 110

20. FILED Feb 14 1942 Arlene Scadden Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 13 1942

22. I HEREBY CERTIFY, That I attended deceased from Nov 20 1941 to _____, 19____

I last saw her alive on Jan 10 1942 Death is said

to have occurred on the date stated above, at 6:30 a.m.

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis ??
Myasthenia Gravidarium Nov.

Other contributory causes of importance:

Chronic Interstitial Nephritis

Name of operation 1310 Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify None

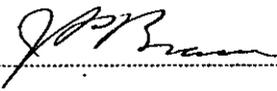
(Signed) J. Healy D.O., M. D.

(Address) Denver Mo.

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. 2847

P. O. Address Denver, Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8177
Registrar's No.

Registration District No. 905 Primary Registration District No. 6216

1. PLACE OF DEATH:

(a) County North Denver
(b) City or town Denver
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth
(c) City or town Denver, Mo.
(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 _____

3. (a) PRINT FULL NAME Rachel A. Sharpe
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Apr. 5
(Month) (Day) (Year)

8. AGE: 78 Years 9 Months 2 Days If less than one day _____ 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 _____
(City, town, or county) (State or foreign country)

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

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

(c) Place: burial, or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb. 14, 1942 (b) Arlene Scudder
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day _____ Year 1942 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
(Immediate cause of death) _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

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