V. S. No. 2
00M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 7 1943

Registration District No. 749

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 17138

Registrar's No. 2037

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Little Sisters of the Poor 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 yrs (Specify whether years, months or days)

In this community 41 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1310 Cleveland 8
and Chanute (If rural, give location) 0

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Amelia Kathrine Sharp

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Wm Sharp

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

7. Birth date of deceased March (Month) 27 (Day) 1860 (Year)

8. AGE: Years 83 Months 1 Days 28 If less than one day ..... hr. ..... min.

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

10. Usual occupation at home

11. Industry or business .....

FATHER
12. Name Geyer
13. Birthplace ..... (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Malinda
15. Birthplace ..... (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Luella Baker
(b) Address 1310 Cleveland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 (Month) 1943 (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. C. S. Foster
(b) Address 918 Brooklyn

19. (a) 5-17-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1943 hour — minute 7:30 P.M.

21. I hereby certify that I attended the deceased from May 8, 1943, to May 15, 1943; that I last saw her alive on May 14, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute myocardial failure	1 day
Due to Bronchial pneumonia	7 day
Due to Arteriosclerosis	Years
Other conditions (Include pregnancy within 3 months of death) 107	

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 U

23. Signature John T. Skinner (M. D. or other) MD
Address 1402 Bryant Bldg. Date signed 5-18-43

(Licensed Embalmer's Statement on Reverse Side)

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 me

, Registered ~~Apprentice~~ No.

working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address KC 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, fact should be so stated above.