No. 2
-8-43
-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10122

FILED APR 15 1944

Registration District No. 1449 Primary Registration District No. 1002 Registrar's No. 1590

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~~: ST. LUKES HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital ~~or institution~~ 1 MONTH (Specify whether years, months or days) In this community 40 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: JACKSON

(c) City or town: KANSAS CITY (If outside city or town limits, write "RURAL")

(d) Street No.: 3205 MORRELL AVENUE (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country: 0

3. (a) PRINT FULL NAME: MRS. KATIE BELLE SHARON

3. (b) If veteran, name war: NO

3. (c) Social Security No.: None

4. Sex: FEMALE

5. Color or race: WHITE

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

6. (b) Name of husband ~~or wife~~: MR. CLARK W. SHARON

6. (c) Age of husband ~~or wife~~ if alive: 72 years

7. Birth date of deceased: JULY (Month) 11 (Day) 1874 (Year)

8. AGE: Years 69 Months 8 Days 27 If less than one day hr. min.

9. Birthplace: PAOLA (City, town, or county) KANSAS (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER 12. Name: ALONZO LIGHT

FATHER 13. Birthplace: New York (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: MORGAN

MOTHER 15. Birthplace: Ireland (City, town, or county) (State or foreign country)

16. (a) Informant: Mr. Clark W. Sharon

(b) Address: 3205 Morrell Ave.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: APRIL 10 1944 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~: MT. MORIAH CEMETERY

18. (a) Signature of funeral director: D. N. Newcomer's Sons

(b) Address: 1401 BRUSH CREEK BLVD.

19. (a) 4-10-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 7 TH year 1944 hour 11 minute 25 A.M.

21. I hereby certify that I attended the deceased from 3-3-44, 19..., to 4-7-44, 19...; that I last saw her alive on 4-6-44, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death (1) Acute myocardial infarction — Duration

(2) Terminal bronchopneumonia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: Cholecystitis & cholelithiasis

Of autopsy: Same as cause of death

PHYSICIAN — Underline the disease which 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: F. H. Hodgson (M.D. or other) MD

Address: 200 Plaza Med Bldg. Date signed: 4-7-44

(Licensed Embalmer's Statement on Reverse Side)

200 Vega Manor
1-5-300

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 E. C. Forthey

Licensed Embalmer No. 1767

P. O. Address Kansas City

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

If this body is not embalmed, fact should be so stated above.