

STANDARD CERTIFICATE OF DEATH

State File No.

1373

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph, Missouri
(c) Name of hospital or institution: Missouri Methodist Hospital
(d) Length of stay: In hospital or institution 20 days
In this community 20 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Doniphan
(c) City or town Severance (Rural)
(d) Street No. Rural
(e) Citizen of foreign country?

3. (a) PRINT FULL NAME Lizzie Frances Sharp

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife William O. Sharp
6. (c) Age of husband or wife if alive 1881 years
7. Birth date of deceased July 10 1881

8. AGE: Years 84 Months 5 Days 10
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Wynne P. Huss
13. Birthplace Ky
14. Maiden name Susan Jones
15. Birthplace Ky

16. (a) Informant Mrs. Emma Miller

(b) Address St. Joseph, Mo.

17. (a) Removal (b) Date thereof Dec 21, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Kansas

18. (a) Signature of funeral director

(b) Address Troy, Kansas

19. (a) Date received local registrar Dec 21, 1945 (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20
year 1945 hour 10:00 minute 20 P.M.

21. I hereby certify that I attended the deceased from Dec 19 1945 to Dec 20 1945
that I last saw her alive on Dec 19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Definite plus probably heart failure.
Due to: Influenza pneumonia, pleurisy, anemia, arteriosclerosis, generalized
Other conditions: all about
Major findings: all points
Of operations: none
Of autopsy: 230

Duration
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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature L. H. Faxon M.D. (St. D. or other)
Address St. Joseph, Mo. Date signed 12/21/45

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

MOTHER FATHER

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. 3532

P. O. Address Troy, Kansas

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.