

S. No. 2  
M-2-43  
5-17-39  
I X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
**FILED APR 29 1946 STANDARD CERTIFICATE OF DEATH**

13366

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1798

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. Joseph Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 weeks  
(Specify whether years, months or days)

In this community 45 years  
(Specify whether years, months or days)

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. 327 No. Indiana Ave.  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Clemons Sharp

3. (b) If veteran, name war No

3. (c) Social Security No. 492-18-4718

4. Sex Female 5. Color or race White

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

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

6. (c) Age of husband or wife if alive 20th years

7. Birth date of deceased July 20th 1880  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th, year 1946 hour 12 minute 25 A. M.

21. I hereby certify that I attended the deceased from file 14 or 14th to April 16, 1946 that I last saw him or alive on April 16, 1946 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>8</u>	<u>26</u>	hr. _____ min. _____

Immediate cause of death Cerebral edema

Generalized arterio

sclerosis

Duration 1 day

Due to \_\_\_\_\_

Other conditions 1860-3

Major findings: 34

Of operations \_\_\_\_\_

of autopsy See above

Tact. fractured femur

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name John T. Clemons

13. Birthplace Ky.  
(City, town, or county) (State or foreign country)

14. Maiden name Minerva Collins

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs A. L. Scott

(b) Address 337 So Monroe Ave.

17. (a) Burial (b) Date thereof 4/18/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Earp Funeral Home

(b) Address 4139 East 15th, St.

19. (a) 4-17-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident suicide, or homicide (specify) no 123

(b) Date of occurrence Feb 14 - 46

(c) Where did injury occur? Kansas City, Mo.  
(City or town) (County) (State)

(d) Did injury occur in \_\_\_\_\_ about home, on farm, in industrial place, in public place?  
Public Place

While at work? \_\_\_\_\_ (Specify type of place)

Means of injury \_\_\_\_\_ (Specify)

Signature Geraldine Holmes (M.D. or other)

Date 4/16/46

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

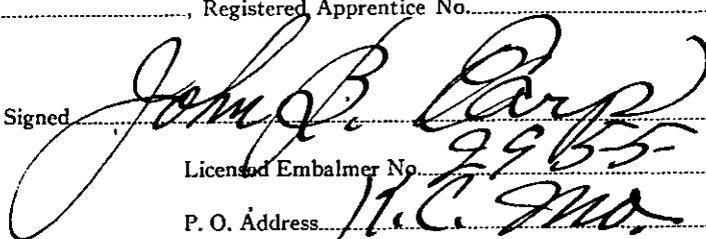
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**STATEMENT BY LICENSED EMBALMER**

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. 9955.....

P. O. Address. N.C. 9mo......

**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.**