

15-43  
-17-39  
X36671

**FILED** APR 19 1946  
Registration District No. 346

**STANDARD CERTIFICATE OF DEATH**

State File No. ....

Primary Registration District No. 6162

Registrar's No. 55

**1. PLACE OF DEATH:**

(a) County Stone

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether)

In this community 7 yr.  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Stone 104

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

(d) Street No. Billings R#1  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** James Arval Sharp

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month Mar. day 15<sup>th</sup>  
year 1946 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 15, 1946, to Mar 15, 1946, that I last saw him alive on March 13, 1946, and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Jan 11 - 1878  
(Month) (Day) (Year)

Immediate cause of death Pneumonia

Due to Pneumonia

Duration 4 weeks

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

Duration 6 weeks

8. **AGE:** Years 68 Months 2 Days 4  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name unknown

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

14. Maiden name \_\_\_\_\_

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

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 ✓

23. Signature H. L. Yerr (M. D. or other)  
Address Crawfordsville Mo. Date signed 3-17-46

16. (a) Informant Lawrence Logan

(b) Address Billings R#1 - Mo.

17. (a) Buried (b) Date thereof Mar 16 - 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hampton cem

18. (a) Signature of funeral director J. W. Maples

(b) Address Clever Mo.

19. (a) 3/29/1946 (b) Carroll Lee Denton  
(Date received local registrar) (Registrar's signature)

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

RECEIVED  
District Health Officer No. 6,  
District File Number 446-483  
Date Filed APR 17 1946

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..... JW Maples  
Licensed Embalmer No. 2985  
P. O. Address Clear 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.

Registration District No. 346

Primary Registration District No. 6165

1. PLACE OF DEATH:

(a) County Stone  
(b) City or town Neal  
(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

3. (a) PRINT FULL NAME JAMES A. THARP  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 11  
(Month) (Day) (Year)

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_  
(If less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
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)  
Place: burial or cremation \_\_\_\_\_

18. Signature of funeral director \_\_\_\_\_  
Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to Bronchial Pneumonia  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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)  
(c) Means of injury \_\_\_\_\_

23. Signature H. P. Yerr (M. D. Brother)  
Address Crane mo Date signed 4-23-46

SUPPLEMENTARY

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

1946

15437