S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 6 1947

Registration District No. 2947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3056

State File No. 14641

Registrar's No. 113

1. PLACE OF DEATH:
(a) County: Randolph
(b) City or town: Moberly RR
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Woodland Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Randolph
(c) City or town: Moberly R R
(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

3. (a) PRINT FULL NAME: Donna Jane Sharron
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Female
5. Color or race: W.
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: ✓
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: 2 (Month) — 8 (Day) — 1947 (Year)

8. AGE: Years | Months: 2 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Moberly (City, town, or county) Mo (State or foreign country)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Glenn Sharron
13. Birthplace: Mendon (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name: Hertha Dailey
15. Birthplace: Mendon RR (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Hertha Fay Sharron.
(b) Address: R3. Moberly, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-30-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Mendon Cemetery
18. (a) Signature of funeral director: Paul A. Thompson
(b) Address: Mendon Mo
19. (a) April 30-47 (Date received local registrar) (b) Leah Hellmann Lowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29th year 1947 hour 12 minute 6 A.M.
21. I hereby certify that I attended the deceased from April 1, 1947, to April 28, 1947 that I last saw him alive on April 28, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Dysentery — type not known — Duration: 20 days
Due to: ?
Due to:
Other conditions (Include pregnancy within 3 months of death): Prematurity
Major findings:
Of operations: N/A
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:
23. Signature: Henry C. Baker (M. D. or other) MD
Address: 208½ N. 4th Street Date signed: April 30 1947

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 5-42-770
Date Filed MAY - 5 1947

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 Mrs Ind A Thompson

Licensed Embalmer No. 3282

P. O. Address Madison, 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.