

Registration District No. **74** Primary Registration District No. **4136**

1. PLACE OF DEATH:
 (a) County **Clayton**
 (b) City or town **Plattsburg**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Home**
 (If not in hospital or institution, write street number or location) **1**
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community **9 months** years, months or days)

3. (a) PRINT FULL NAME **Leola Sharp**
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex **female** **5. Color or race** **white** **6. (a) Single, widowed, married,** **divorced** **widow**
(b) Name of husband or wife **Joseph M Sharp** **6. (c) Age of husband or wife if** **deceased**
7. Birth date of deceased **Dec 25 1874**
 (Month) (Day) (Year)

8. AGE: Years **73** Months **10** Days **14** If less than one day hr. min.

9. Birthplace **Cincinnati Ohio**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife - at home**

11. Industry or business **Unknown**

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Jos. S. Sharp**
(b) Address **Smithville, Mo. R.F.D.**

17. (a) Burial, cremation, or removal **Burial** **(b) Date thereof** **11-10-47**
 (Month) (Day) (Year)

(c) Place: burial or cremation **Smithville, Mo.**
18. (a) Signature of funeral director **McConroe Funeral Home**
(b) Address **Smithville, Mo.**
19. (a) Nov 8 - 1947 **(b) Bernice Chastain**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Clay 24**
 (c) City or town **Smithville**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov** day **8**
 year **1947** hour **9:** minute **2** A.M.
21. I hereby certify that I attended the deceased from **Aug 20**
1947 to **Nov 8** 1947
 that I last saw her alive on **Nov 1** 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death **myocarditis**
 Due to _____
 Due to _____
 Other conditions **93F**
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: **none**
 Of operations _____
 Of autopsy **none**

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 **0**
23. Signature **W. B. Stalding** (M. D. or other) **MO**
Address **Plattsburg Mo** **Date** **Nov 8 - 47**

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

MOTHER FATHER

Dr.
~~*Dr.*~~

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *S. R. McComas*.....
Licensed Embalmer No. *2303*.....
P. O. Address..... *Smithville, 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.