FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 6 1947

Registration District No. 848

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 40175 10853

Registrar's No.

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

2. USUAL RESIDENCE OF DECEASED:
(a) State: Ill (b) County: St Clair
(c) City or town: E. St Louis (If outside city or town limits, write "RURAL")
(d) Street No.: 716 Brady Ave (If rural, give location): NR
(e) Citizen of foreign country? (Yes or No):
If yes, name country:

3. (a) PRINT FULL NAME: Mary Sharp
3. (b) If veteran, name war: no
3. (c) Social Security No.: 332-16-2724
4. Sex: F
5. Color or race: Col
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Raymond Sharp
6. (c) Age of husband or wife if alive: 47 years
7. Birthdate of deceased: 5 (Month) 10 (Day) 1915 (Year)

8. AGE:

Years	Months	Days	If less than one day
32	6	15	hr. min.

9. Birthplace: Columbus (City, town, or county) Miss. (State or foreign country)
10. Usual occupation:
11. Industry or business: Home Wife
FATHER
12. Name: Frank Lash
13. Birthplace: (City, town, or county) Miss. (State or foreign country)
MOTHER
14. Maiden name: Florence Tucker
15. Birthplace: (City, town, or county) Miss. (State or foreign country)
16. (a) Informant: Florence Lash
(b) Address: E. St. Louis, Ill.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 11/26/47 (Month) (Day) (Year)
(c) Place: burial or cremation: St Clair County Ill
18. (a) Signature of funeral director: A M Green
(b) Address: 3517 Saulcde ave
19. (a) NOV 26 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov day: 25 year: 1947 hour: 7 minute: 00 a.m.
21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....; that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Cause and Manner of Coma	
Due to: Could not be determined	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autops.:

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): Not Verified
(b) Date of occurrence: Not
(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? (Specify type of place)
While at work? (e) Means of injury: Not above
23. Signature: (M. D. or other)
Address: Sidney Coroner Date signed: 11/26/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

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 [signature]

Licensed Embalmer No. 1173

P. O. Address 1318 E. Belway

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.