

FILED FEB 13 1948

Registration District No. 279

Primary Registration District No. 3052

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bathwell Hosp. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 hrs
In this community 8 hrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis 80
(c) City or town Sedalia 6
(If outside city or town limits, write "RURAL") 4
(d) Street No. 1100 S. Massachusetts
(If rural, give location) 0
(e) Citizen of foreign country? - (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Michael Joseph Sharon

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased Jan 27, 1948
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 8 hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Chas. T. Sharon

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

14. Maiden name Agnes J. Sullivan

15. Birthplace Spring Fork, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. T. Sharon

(b) Address 1100 So Mass. Sedalia, Mo

17. (a) Burial (b) Date thereof 1-29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Balvary Cem.

18. (a) Signature of funeral director M. P. Fyfe

(b) Address 515 So. Ohio, Sedalia, Mo

19. (a) 1-29-48 (b) Betty Yeager
(Date received local registrar) (Date of signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27
year 1948 hour 3:30 P. M.

21. I hereby certify that I attended the deceased from Jan 27 1948 to Jan 27 1948
that I last saw him alive on Feb 27 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Hydrocephalic Cerebr. Duration _____

Due to _____

Due to _____

Other conditions Congenital malformation
(Include pregnancy within months of death)
including Club Foot Rt

Major findings: Of operations _____

Of autopsy 157A

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

(c) 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? 0

While at work? _____ (Specify type of place)

(b) Means of injury _____

23. Signature W. D. Schenker (M. D. or other) 240

Address Sedalia, Mo Date signed 1/29/48

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

MOTHER FATHER

RECEIVED

District Health Officer

District File Number

Date Filed

2-11-48

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

R.P.M. Gray

Licensed Embalmer No. 3153

P. O. Address Sedalia 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.