

FILED JUN 3 1949

STANDARD CERTIFICATE OF DEATH

State File No. 15439

BIRTH NO. _____ REG. DIST. NO. 105 PRIMARY REG. DIST. NO. 4177 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Clarkton</u> c. LENGTH OF STAY (If this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Clarkton</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Samuel b. (Middle) Calhoun c. (Last) Sharp 4. DATE OF DEATH (Month) (Day) (Year) May 13 1949

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH July 20 1889 9. AGE (In years last birthday) 59 IF UNDER 1 YEAR Months 9 Days 23 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper, Accountant 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME James Sharp 13b. MOTHER'S MAIDEN NAME Mattie James 14. NAME OF HUSBAND OR WIFE Hettie Sharp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME Charles James Clarkton ADDRESS M.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL FAILURE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) aortic insufficiency

DUE TO (c) chronic Valvular Heart Disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

21a. ACCIDENT (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from at 48, 1949, to May 13, 1949, that I last saw the deceased alive on May 13, 1949, and that death occurred at 1:00 p m., from the causes and on the date stated above.

23a. SIGNATURE J. B. Hopkins, M.D. (Degree or title) 23b. ADDRESS Si Leone, Mo 23c. DATE SIGNED 5-17-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE May 15, 1949 24c. NAME OF CEMETERY OR CREMATORY Park Cemetery 24d. LOCATION (City, town, or county) (State) Malden Mo.

DATE REC'D BY LOCAL REG. 5-25-49 REGISTRAR'S SIGNATURE Freida Bailey 88 25. FUNERAL DIRECTOR'S SIGNATURE Landess Funeral Home ADDRESS Campbell, Mo.

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

RECEIVED

District Health Office No. 2,

District File Number

5496-2

Date Filed

5-31-29

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Christina M. Landess*

Licensed Embalmer No. *4227*

P. O. Address *Campbell, 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.