

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

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **22176**

FILED JUN 27 1949

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **676** Registrar's No. **1252**

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MANCHESTER 4	c. LENGTH OF STAY (In this place) 2 YRS 2 MOS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION MANCHESTER NURSING HOME		d. STREET ADDRESS (If rural, give location) 4218 HOLLY	

3. NAME OF DECEASED (Type or Print) MABEL	a. (First)	b. (Middle)	c. (Last) SHARP	4. DATE OF DEATH (Month) 5 (Day) 18 (Year) 49
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH FEB 6 18 86	9. AGE (In years last birthday) 63	If UNDER 1 YEAR Months 3 Days 17	If UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) ST LOUIS	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John C JONES	13b. MOTHER'S MAIDEN NAME SUSIE HILL	14. NAME OF HUSBAND OR WIFE CHARLES SHARP
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE, OR NAME Lillian S. Wirth	ADDRESS 10432 LACKLAND
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac failure		sudden
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Old Lt. cerebral hemiplegia 5 yrs		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 44 X 83			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb 7, 1946** to **May 18, 1949**, that I last saw the deceased alive on **5-18, 1949**, and that death occurred at **6:50 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) P. H. Denny M.D.	23b. ADDRESS Cress Cooper, MO	23c. DATE SIGNED 5-20-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/21/49	24c. NAME OF CEMETERY OR CREMATORY ZION CEMETERY	24d. LOCATION (City, town, or county) (State) WELLSSTON MO
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DATE REC'D BY LOCAL REG. 5-21-49	REGISTRAR'S SIGNATURE Theresa L. ...	25. FUNERAL DIRECTOR'S SIGNATURE BAUMANN BROTHERS, INC	ADDRESS OVERLAND MO
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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 345

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland 14

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.