

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045294

STATE FILE NUMBER

FILED JAN 8 1959 Registration District No. 314 Primary Registration District No. 6066 Registrar's No. 55

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Cass	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Roscoe		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Pleasant Hill
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1 Mile north		Length of stay in 7b 1 da.	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Homer Clyde Sharp			4. DATE OF DEATH Month Day Year 12 28 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 23 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years at birthday) 64
13a. FATHER'S NAME John W. Sharp		13b. MOTHER'S MAIDEN NAME Sallie May	9. AGE (In years at birthday) 64
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	10. CITIZEN OF WHAT COUNTRY? U.S.A.
17. INFORMANT Lois Sharp		Address Pleasant Hill Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary thrombosis DUE TO (c) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 10 Min 10 Min Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 28 Dec 58 to 28 Dec 58 and last saw him alive on 28 Dec 58 Death occurred by 9:15 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE A. H. Lesler MD		22b. ADDRESS Osceola Mo	
22c. DATE SIGNED 29 Dec 58			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12/31/58	23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill	23d. LOCATION (City, town, or county) (State) Pleasant Hill Mo
24. FUNERAL DIRECTOR Goodrich F. Home		ADDRESS @ Osceola Mo	25. DATE RECD. BY LOCAL REG. 1-2-59
		26. REGISTRAR'S SIGNATURE Ruth Seewers	

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

85
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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Paul J. [Signature]*

Licensed Embalmer No. *3990*

P. O. Address *[Signature]*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.