

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040370

FILED VS DEC 10 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5796

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>64 yrs</b>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2316 Troost</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>SHARNEE</b> Last <b>SHARNEE</b>			4. DATE OF DEATH Month <b>11th</b> Day <b>29th</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/95</b>	9. AGE, (last birthday) <b>64</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery Co. Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>AUSTIN SHARNEE</b>		13b. MOTHER'S MAIDEN NAME <b>Mamie Kemp</b>		14. NAME OF HUSBAND OR WIFE <b>Sarah Sharnee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>495-09-2081</b>		17. INFORMANT Address <b>VA HOSPITAL OFFICIAL RECORDS, K. C. MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease with aortic stenosis</b>					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Encephalomalacia</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____	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. Attended the deceased from <b>11-5-59</b> to <b>11-29-59</b> Death occurred at <b>7:01 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree, title) <b>Albert J. Chasson M.D.</b>			22b. ADDRESS <b>VA Hospital, K. C. Mo.</b>		22c. DATE SIGNED <b>11/29/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>12-3-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fort Leavenworth, Kansas</b>
24. FUNERAL DIRECTOR <b>Mrs. Meek's Mortuary, K. C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-1-59</b>	26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
**Albert J. Chasson**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Millard B. Pask

Licensed Embalmer No. 5013

: P. O. Address K.C. 7

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.