MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-028203
STATE FILE NUMBER

AMENDED

Registration District No. 373 Primary Registration District No. 6269 Registrar's No. 37

FILED JUL 17 1961

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO.

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY: WEBSTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: OZARK TWP
Length of stay in 1b: 2 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION:
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: KAN b. COUNTY: WYANDOTTE
c. CITY OR TOWN: KANSAS CITY KANS
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1819 GLENDALE
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MARY Middle S Last SHARP
4. DATE OF DEATH: Month JULY Day 10 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 9-9-1873
9. AGE (last Birthday): 87
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): KANSAS
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: FREDRICK HAHN
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE:
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.: —
17. INFORMANT: GEORGE SHARP Address: KANSAS CITY KANS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE EXSANGUINATION
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) RUPTURED AORTIC ANEURYSM (THORACIC)
DUE TO (c) ARTERIOSCLEROSIS
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
PUBLIC HEALTH OFFICER - DID NOT ATTEND
21. I attended the deceased from ____ to ____ and last saw her/him alive on ____
Death occurred at 9:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): [signature], M.D.
22b. ADDRESS: Marshfield, Mo
22c. DATE SIGNED: 7/11/61
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 7-13-1961
23c. NAME OF CEMETERY OR CREMATORY: HOLSAPPLE
23d. LOCATION (City, town, or county) (State): ST CLAIR CO MO
24. FUNERAL DIRECTOR: BARBER-EDWARDS ADDRESS: MARSHFIELD
25. DATE RECD. BY LOCAL REG.: 7-12-61
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

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 George Stapf

Licensed Embalmer No. 3161

P. O. Address Mt. Airy, MD

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.