

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-002009

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

473

STATE FILE NUMBER

AMENDED
DATE AMENDED
INSTEAD OF
DOCUMENT
BY AFFIDAVIT OF
MEDICAL CERTIFICATION
SHOULD READ
TYPEWRITER RIBBON

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

FILED FEB 15 1962

1. PLACE OF DEATH
 a. COUNTY Jackson
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in 1b 30 yrs.
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY JACKSON
 c. CITY OR TOWN KANSAS CITY Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 1620 CENTRAL Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last John Clint Sharp
 4. DATE OF DEATH Month Day Year 1 26 62

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 10-26-81 9. AGE (last birthday) 80 IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK 10b. KIND OF BUSINESS OR INDUSTRY KANSAS CITY HOTEL 11. BIRTHPLACE (City and state or country) TAYLOR COUNTY, IOWA 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME William G. Sharp 13b. MOTHER'S MAIDEN NAME MARIA Nelson 13c. NAME OF HUSBAND OR WIFE UNKNOWN.

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. 35 17. INFORMANT Address Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)
 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

21. I attended the deceased from 1-23-62 to 1-26-62 and last saw ^{her} him alive on 1-26-62
 Death occurred 9:40 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] 22b. ADDRESS 3400 Cherry 22c. DATE SIGNED 1-26-62

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 1-26-62 23c. NAME OF CEMETERY OR CREMATORY Bedford IOWA 23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR ADDRESS D.W. Newcomer S.W. 14th St. 25. DATE RECD. BY LOCAL REG. 1-26-62 26. REGISTRAR'S SIGNATURE Ruth Long

VS FEB 15 1962

1921, 025-0

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 James T. Decker

Licensed Embalmer No. 4453

P. O. Address Lawrence City

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.