

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009422

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 583

DO NOT WRITE ON THIS STUB

AMENDED

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1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILL. b. COUNTY SANGAMON	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO.		Length of stay in 1b 18 DAYS	c. CITY OR TOWN RIVERTON Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) East Menard Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL E. SHARP			4. DATE OF DEATH Month Day Year 2-18-62		
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 11-30-76	9. AGE (last birthday) 85 YEARS	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY CEMETERY	11. BIRTHPLACE (City and state or country) KANE HILL, ARK.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME EDWARD SHARP		13b. MOTHER'S MAIDEN NAME EVELYN WEST		14. NAME OF HUSBAND OR WIFE MARTHA SHARP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES SPAW		16. SOCIAL SECURITY NO. MARTHA SHARP (Wife)		Address East Menard, Riverton, Ill.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 27 DAYS
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT			
DUE TO (b) GENERALIZED ARTERIOSCLEROSIS			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROTIC HEART DISEASE			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 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 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. Amended the deceased from 1-31-62 to 2-18-62
 Death occurred at 4:25 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) DR. MIGUEL MYROL, M.D.	22b. ADDRESS VET. ADM. HOSPITAL, JEFF. BRKS., MO.	22c. DATE SIGNED 2-18-62
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23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
REMOVAL	Feb 21, 61	Camp Butler National	Springfield, Ill

24. FUNERAL DIRECTOR Ellinger & Kunz	ADDRESS Springfield, Ill	25. DATE RECD. BY LOCAL REG. 2-19-62	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

MAR 23 1962

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 Not Embalmed Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Keith Savage

Licensed Embalmer No. _____

P. O. Address _____

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.