

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-023405

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 3419

FILED JUL 16 1962

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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, MISSOURI</b>		Length of stay in lb <b>26 Hours</b>	c. CITY OR TOWN <b>KANSAS CITY, MO.</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, KC, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3520 Kensington, KC, Mo.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CHARLES E. SHARP</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>27</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</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>1/28/96</b>
9. AGE (last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>OSCEOLA, MO.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>WILLIAM S. SHARP</b>	13b. MOTHER'S MAIDEN NAME <b>LUCY TAYLOR</b>
14. NAME OF HUSBAND OR WIFE <b>LEONA SHARP</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes 9/19/17 to 5/12/19</b>	16. SOCIAL SECURITY NO. <b>UNK</b>
17. INFORMANT <b>VA HOSPITAL RECORDS</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>Obstructive mucous bronchitis</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) <b>Bronchopneumonia, left lower lobe</b>			
DUE TO (c) <b>Coronary arteriosclerosis, advanced</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>(d) Esophagitis, hemorrhagic, marked Pulmonary emphysema, advanced</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. I attended the deceased from <b>6/26/62</b> to <b>6/27/62</b> and last saw him alive on <b>6/27/62</b> Death occurred at <b>8:05 PM 6/27/62</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Type or print) <b>STEPHEN PARKS M.D.</b>	22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	22c. DATE SIGNED <b>6-28-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JUNE 28, '62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>APPLETON CITY CEMETERY</b>	23d. LOCATION (City, town, or county) <b>APPLETON CITY, MISSOURI</b>
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS</b>	ADDRESS <b>1331 BRUSH CR. KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>6-28-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth H. Long</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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 Raymond M. Hardy  
Licensed Embalmer No. 4913

P. O. Address Indy, Mo

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.