

FILED NOV 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38368

State File No. _____

Registrar's No. 235

BIRTH NO. _____		REG. DIST. NO. <u>296</u>		PRIMARY REG. DIST. NO. <u>4445</u>		State File No. _____		Registrar's No. <u>235</u>																		
1. PLACE OF DEATH a. COUNTY <u>Ray</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> COUNTY <u>Ray</u>																						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Orrick</u>			c. LENGTH OF STAY (In this place)			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Orrick</u>			d. STREET ADDRESS (If rural, give location)																	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>None</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 5, 49</u>																						
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Hiram</u>		b. (Middle) <u>Marion</u>		c. (Last) <u>Sharp</u>		5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 23, 1860</u>		9. AGE (In years last birthday) <u>88</u>		F UNDER 1 YEAR Months		F UNDER 24 HRS. Days		F UNDER 1 MIN. Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>														
13a. FATHER'S NAME <u>Anderson Sharp</u>				13b. MOTHER'S MAIDEN NAME <u>Nellie Dowden</u>				14. NAME OF HUSBAND OR WIFE <u>Tryphosa Ellen Bogart</u>																		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Nellie Mills</u>						ADDRESS <u>Orrick, Mo.</u>														
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy</u> ANTECEDENT CAUSES DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Retention of Urine Empty Prostate Gland</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH <u>3 3/4 X</u>														
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)																						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?																						
22. I hereby certify that I attended the deceased from <u>Nov 1-49</u> , 19___, to <u>Nov 5-49</u> , 19___, that I last saw the deceased alive on <u>11-5-49</u> , 19___, and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above.																										
23a. SIGNATURE <u>[Signature]</u>				(Degree or title) <u>V.S.O.</u>		23b. ADDRESS <u>Orrick, Mo.</u>		23c. DATE SIGNED <u>11-5-49</u>																		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 6, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Siegel Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>5 Mi S*E of Orrick, Mo.</u>																				
DATE REC'D BY LOCAL REG. <u>11-7-49</u>		REGISTRAR'S SIGNATURE <u>Helen J. Larkin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B. W. Good</u>		ADDRESS <u>Orrick, Mo.</u>																				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 17 1949

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed

11-18-49

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 _____

Self

working under my personal supervision.

Student Embalmer No. _____

Signed

Victor E. Janning

Signed _____

Student Embalmer

Licensed Embalmer No. _____

2846

P. O. Address

Liberty, 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 this body is not embalmed, fact should be so stated above.