

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

745
 Do not use this space.

REC'D FEB 10 1939

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (c) City..... **St. Louis, Mo.** (d) Street No. **St. Louis Childrens Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Robert Thorpe
 (a) Residence, No. **R.R.#2 Granite City, Illinois**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **m** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Child**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Child**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **2-8-34**
 7. AGE YEARS **4** MONTHS **11** DAYS **15** If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Child**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Child**
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1/23** 19**39**
 22. I HEREBY CERTIFY, That attended deceased from **1/22** 19**39**, to **1/23** 19**39**
 I last saw him alive on **1/23** 19**39** Death is said to have occurred on the date stated above, at **2:30** p.m.
 The principal cause of death and related causes of importance were as follows:

Acute myocardial failure caused by infection of nose and throat - from J.B. non-tubercular cause unknown
150

Other contributory causes of importance:
Acute hemorrhagic nephritis 1-20-39
caused by infection in nose + throat non-tubercular non-degenerative
 Name of operation Date of operation
 What test confirmed diagnosis? Was there an autopsy? **yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) **R. J. Blatter**, M. D.
 (Address) **1500 So. Kemp**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **MACCOURIN COUNTY ILLINOIS**

FATHER 13. NAME **Frank Thorpe**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **TERSEVILLE ILLINOIS**

MOTHER 15. MAIDEN NAME **Hulda Armstrong**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **S. SPRINGFIELD ILLINOIS**

17. INFORMANT (ADDRESS) **M. E. Matthews 300 S. Kingshighway**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Hettick, Illinois** DATE **1-26** 19**39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Albert H. Hoppe, Inc. 4700 Washington Blvd**

20. FILED **JAN 24 1939** **J. J. Beck** Local Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Registered Apprentice No., working under my personal supervision.

Signed.....

J. G. Sullivan

Licensed Embalmer No. 1122

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 this body is not embalmed, above space should be left blank.