

FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 5556

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 781

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
7012 Agnes 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City, Mo  
(If outside city or town limits, write "RURAL")  
0 7012 Agnes  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME Trice William Thorp

8. (b) If veteran, name war No 8. (c) Social Security No. 495-01-3327

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Dec. 8, 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
58 2 8 hr. min.

9. Birthplace Platte County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Geo. Cope & Son Contractor

12. Name T. D. Thorpe

13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace Mary E. McCray Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Bert Thorp  
(b) Address 7012 Agnes

17. (a) Burial (b) Date thereof Feb. 21, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missional Park

18. (a) Signature of funeral director H. V. Lindsey & Sons  
(b) Address 3811 Broadway

19. (a) Feb. 20, 1940 (b) Mo. McCray  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17th  
year 1940 hour 7 minute 55 P. M.

21. I hereby certify that I attended the deceased from Feb. 17<sup>th</sup>  
1940 to Feb. 17, 1940  
that I last saw him alive on Feb. 17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia  
Chronic bronchitis, asthma Duration 3 day

Due to 1076

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature H. V. Lindsey (M. D. or other) D.  
Address 80 + + Park Date signed 2/19/40

PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

*Dr. Geo. Jones*  
*809 Park*  
*2-5*  
*Remains*

**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 *Roscoe H. Keeler*  
Licensed Embalmer No. *13738*  
P. O. Address *K.C. 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, above space should be left blank.**