

S. No. 2
OM-5-43
v. 5-17-39
I X36671

FILED MAY 3 1945

Registration District No. 197

Primary Registration District No. 1002

Registrar's No. _____

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 18 days
(Specify whether years, months or days)

In this community 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴⁸

(c) City or town Kansas City ³
(If outside city or town limits, write "RURAL")

(d) Street No. 1516 Wyandotte
(If rural, give location)

(e) Citizen of foreign country? () (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME E. Floyd Tharp

3. (b) If veteran, name war no

3. (c) Social Security No. 199-07-7309

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Mamie Tharp

6. (c) Age of husband or wife if alive ***** years

7. Birth date of deceased May 25 1892
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	62	10	17	_____ hr. _____ min.

9. Birthplace Polk Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Trucker

MOTHER FATHER

11. Industry or business _____

12. Name John Tharp

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

14. Maiden name Marvella Fender

15. Birthplace Ind
(City, town, or county) (State or foreign country)

16. (a) Informant Rainie Tharp

(b) Address 1426 Summerville

17. (a) Removal (b) Date thereof Apr 18-1945
(Reason, occasion, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Ind

18. (a) Signature of funeral director Mark R. Fortner

(b) Address 918 Broadway

19. (a) 4-18-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
year 1945 hour 8 minute 10 P.M.

21. I hereby certify that I attended the deceased from February 25, 1945 to April 12, 1945
that I last saw him alive on April 12, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac asthma Duration _____

Due to _____

Due to _____

Other conditions 95°C
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None

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

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)

(c) Means of injury Car

23. Signature Clark W. Sealy MD (M.D. or other)
Address Med. Dir. Gen'l Hosp Date signed 4-13-45

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

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

Carlton Minor

Licensed Embalmer No.

3414

P. O. Address

918 Brooklyn

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.