No. 2
—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28233

FILED SEP 14 1945

Registration District No. 944

Primary Registration District No. 5944

Registrar's No.

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Green Temp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk 64

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

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME Andrew Jackson Thorp

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex .....

5. Color or race .....

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

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

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

7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 18 If less than one day ..... hr. ..... min.

9. Birthplace Indinia / (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farmer

FATHER
12. Name John Thorp
13. Birthplace Indinia / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Julia Kembrlin
15. Birthplace Ill. / (City, town, or county) (State or foreign country)

16. (a) Informant Charles Thorp
(b) Address Kirksville Mo.

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation Polk Town

18. (a) Signature of funeral director L. B. Jones
(b) Address Buffalo, Mo.

19. (a) Aug. 10 '45 (Date received local registrar) (b) Ora Wrinkle (Registrar's signature)

1989

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9
year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from On May 1, 1945 to ....., 19....;
that I last saw him alive on On May 1, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma prostate	
Due to Gland	1 yr
Due to Cause unknown	
Other conditions Cystitis (Include pregnancy within 3 months of death)	

Major findings:
Of operations 5 lb
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? .....
(Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature G. H. Klemmer (M. D. or other) MD

Address Buffalo Mo Date signed 8-10-45

(Licensed Embalmer's Statement on Reverse Side)

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 Marvis B. Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, 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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 284 Primary Registration District No. 5974 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Rural Green Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Polk

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Andrew Jackson Thorp

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 18 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name John Thorp
13. Birthplace (City, town, or county) Indiana (State or foreign country)

MOTHER
14. Maiden name Julia Kemberlin
15. Birthplace (City, town, or county) Ill. (State or foreign country)

16. (a) Informant Charles Thorp
(b) Address Kirksville, MO

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Polk town

18. (a) Signature of funeral director L. B. Jones
(b) Address Buffalo, MO

19. (a) (Date received local registrar) (b) Cora Wrinkle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from May 1, 19 to , 19 ; that I last saw h alive on May 1, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Prostate gland

Due to Cause Unknown

Due to

Other conditions Cystitis
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature G. C. Plummer MD (M. D. or other)

Address Buffalo, MO Date signed Aug-[illegible]

5- 28233