V. S. No. 2
DM—9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 2 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2314

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 7

14
1
2

310

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

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital no 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 yrs 3 months 7 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Rolla 14

(c) City or town New London 1
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME CHARLES E THORP

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 0

5. Color or race W

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

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

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased May (Month) 15 (Day) 1865 (Year)

8. AGE: Years 80 Months 7 Days 19 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name James Thorp
13. Birthplace England 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha King
15. Birthplace Virginia 1 (City, town, or county) (State or foreign country)

16. (a) Informant Record
(b) Address

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/5/46 (Month) (Day) (Year)
(c) Place: burial or cremation Hannibal, Mo

18. (a) Signature of funeral director Wallace Funeral Home
(b) Address Fulton, Mo

19. (a) 1-5-1946 (Date received local registrar) (b) Josie Moisiuchoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4 year 1946 hour 4:30 minute P M.

21. I hereby certify that I attended the deceased from Jan 1, 1946 to Jan 4, 1946 that I last saw him alive on Jan 3, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar pneumonia (terminal)	28 hrs
Due to mitral insufficiency	3 yrs
Due to arteriosclerosis	10 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 108

Of autopsy terminal pneumonia mitral insufficiency arteriosclerosis

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 Joseph Imperatrice (M. D. or other M.D.)

Address State Hospital no 4 Date signed 1/5/46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 2-1-46

FEB 7 1946

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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address Fulton 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.