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

FILED AUG 13 1946

State File No. 234457

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 72

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: West Plains Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 816 Morgan
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Tony Wm Throper
3. (b) If veteran, name war ✓
3. (c) Social Security No.
4. Sex Mo
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Opal Throper
6. (c) Age of husband or wife if alive 29 years
7. Birth date of deceased 9-13-1916 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
29	10	12	hr. min.

9. Birthplace Baxter, Mo (City, town, or county) (State or foreign country)
10. Usual occupation Mechanic
11. Industry or business
MOTHER FATHER
12. Name Jno Throper
13. Birthplace Kennett Mo (City, town, or county) (State or foreign country)
14. Maiden name Nettie Bilyeu
15. Birthplace Baxter, Mo (City, town, or county) (State or foreign country)
16. (a) Informant Mary Nieu
(b) Address St Joseph, Mo
17. (a) R (Burial, cremation, or removal) (b) Date thereof 7/29-46 (Month) (Day) (Year)
(c) Place: burial or cremation St Joseph Mo
18. (a) Signature of funeral director Rotherham
(b) Address West Plains Mo
19. (a) July 29, 1946 (Date received local registrar) (b) Gladys Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 26 year 1946 hour minute M.
21. I hereby certify that I attended the deceased from 7/26, 1946 to 7/26, 1946 that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Internal hemorrhage	
Due to	
Due to Stab wound in Chest	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operation
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Maurice Hawson (M. D. or other) M.D.
Address West Plains Mo Date signed 7/29/46

125 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 946477
Date Filed 8-13-46

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 Paige D Roberts

Licensed Embalmer No. 3433

P. O. Address West Hartford Me

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.

E. No. 2B
5M—3-45
I X43880

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

22343

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 141 Primary Registration District No. 3025 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Howell

(b) City or town West Plains
(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 (b) County

(c) City or town
(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 Tony Wm Phieper

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 18 1946
(Month) (Day) (Year)

8. AGE: Years 29 Months 10 Days 12 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 26
year 1946 hour minute M.

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

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

167

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) Homicide

(b) Date of occurrence 7/25/46

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Picnic Grounds
(Specify type of place)
While at work? no. (e) Means of injury Knife

23. Signature Manuel Thompson (M. D. or other) MD
Address West Plains MO Date signed 9/19/46

23457