No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 19 1947

Registration District No. 8

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37524

Primary Registration District No. 3017

Registrar's No. 174

1. PLACE OF DEATH:
(a) County: Cooper
(b) City or town: Boonville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Alex VanRavenswaay Hospital (If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution: 1 Week (Specify whether years, months or days)
In this community: Most of life.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Cooper 27
(c) City or town: Wooldridge (If outside city or town limits, write "RURAL") 0
(d) Street No.: — (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: — 0

3. (a) PRINT FULL NAME: Joseph Claud Tharp.
3. (b) If veteran, name war: —
3. (c) Social Security No. 493-28-8802

4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: W 1
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: September (Month) 4th (Day) 1883 (Year)

8. AGE:

Years	Months	Days	If less than one day
64	2	5	hr. min.

9. Birthplace: Osage County, (City, town, or county) Missouri. (State or foreign country) 0
10. Usual occupation: Farmer
11. Industry or business: On farm
FATHER
12. Name: Francis Marion Tharp.
13. Birthplace: Kentucky (City, town, or county) (State or foreign country) 1
MOTHER
14. Maiden name: Mary C. Brady.
15. Birthplace: Ohio. (City, town, or county) (State or foreign country) 1
16. (a) Informant: Mrs. Raymond Coffman.
(b) Address: Wooldridge, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 11th/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Mint Hill, Mo.
18. (a) Signature of funeral director: Goodman & Boller.
(b) Address: Boonville, Mo.
19. (a) 11-11-47 (Date received by local registrar) (b) [illegible] (Registrar's signature) 201

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov. day: 9th. year: 1947 hour: 7 minute: a. M.

21. I hereby certify that I attended the deceased from: Nov 3, 1947, to: Nov 9, 1947, that I last saw him alive on: Nov 8, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia	1 month
Due to: Apoplexia cerebri	
Due to: Hypertension + Arteriosclerosis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN — Underline the cause of 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: [illegible] (M. D. or other)
Address: Boonville Mo Date signed: 11.11.47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 11-18-47

NOV 20 1947

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 Wm W Wood, Registered Apprentice No. 480, working under my personal supervision.

Signed G. F. Boller

Licensed Embalmer No. 3062

P. O. Address Boonville, 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.