

FILED MAY 11 1949

## STANDARD CERTIFICATE OF DEATH

14218  
State File No. 3950

BIRTH NO.		REG. DIST. NO. 218		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.				c. LENGTH OF STAY (in this place) 14 days		a. STATE Illinois	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Barnes Hospital. 0				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marion		b. COUNTY Williamson 777	
3. NAME OF DECEASED (Type or Print) Eula				a. (First) Lee		b. (Middle) Tharp	
4. DATE OF DEATH (Month) (Day) (Year) April 30 1949				5. SEX Female			
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Unk		9. AGE (In years last birthday) Months Days Hours Min. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Marion	
13a. FATHER'S NAME John Pernod		13b. MOTHER'S MAIDEN NAME Bessie Oneil		14. NAME OF HUSBAND OR WIFE Lom Tharp			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lom Tharp Marion Ill			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rheumatic heart disease, inactive, valvular ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart failure				INTERVAL BETWEEN ONSET AND DEATH 20 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 935			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1116X			
22. I hereby certify that I attended the deceased from April 15, 1949, to April 30, 1949, that I last saw the deceased alive on April 30, 1949, and that death occurred at 2:55 A.M., from the causes and on the date stated above.							
23a. SIGNATURE H. Bradley 0 M.D. (Degree or title)				23b. ADDRESS Barnes Hospital.		23c. DATE SIGNED 4/30/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4/30/49		24c. NAME OF CEMETERY OR CREMATORY Wolf Creek		24d. LOCATION (City, town, or county) (State) Eldorado Ill	
DATE REC'D BY LOCAL REG. MAY 2 1949		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe-4700 Washington Blvd			

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Elmer R. Cadwell*

Licensed Embalmer No. 4077

P. O. Address \_\_\_\_\_

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.