

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27227**
3437

FILED AUG 25 1951

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Wyandotte	
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) 16 days		d. STREET ADDRESS (If rural, give location) 841 Minnesota	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Vernon U.	b. (Middle)	c. (Last) Thrash	4. DATE OF DEATH (Month) (Day) (Year) Aug. 9, 1951
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 16, 1897	9. AGE (in years) (Month) (Day) (Hour) (Min.) 54
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) brakeman	10b. KIND OF BUSINESS OR INDUSTRY Missouri Pacific R.R.	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Luther Brown Thrash	13b. MOTHER'S MAIDEN NAME Cora Lee Williams	14. NAME OF HUSBAND OR WIFE Mattie Mae Thrash
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W. W. #1	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mattie Mae Thrash, 841 Minn. K. C. K.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute left adrenal hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 6 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Cardiovascular Renal Dis.		
	DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Progressive left posterior V. Myoc. Inf.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 20, 1950, to Aug 9, 1951, that I last saw the deceased alive on Aug 8, 1951, and that death occurred at 5:45 Am., from the causes and on the date stated above.

23a. SIGNATURE Donald J. Smith (Degree or title)	23b. ADDRESS 1002 Apple Blde K. C. Mo.	23c. DATE SIGNED Aug 9, '51
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 8-9-51	24c. NAME OF CEMETERY OR CREMATORY Keytesville	24d. LOCATION (City, town, or county) (State) Keytesville, Mo.
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DATE REC'D BY LOCAL REG. 8-10-51	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE UND. CO. KANSAS CITY, MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 27 1951

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Gerald A. Burger

Signed.....
Student Embalmer

Licensed Embalmer No. 4763

P. O. Address Kansas City, 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.