

FILED APR 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11871

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 65

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | |
|--|---------------------------|--|-------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Vernon | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stone | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN None Given | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp #3 | | Length of stay in lb 2 | | d. STREET ADDRESS None Given | | Reside on Farm (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Rosie Middle Lathrop Last Lathrop | | | | 4. DATE OF DEATH Month March Day 28 Year 1957 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Jan 23 1882 | 9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months 2 Days 5 | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (City and state or country) Douglas Co Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas B. Lathrop | | | | 14. MOTHER'S MAIDEN NAME Martha C. Hill | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Hospital Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic Shock From Pelvic Fracture | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 Hrs | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | DUE TO (b) Fracture of the Rt Femur | |
| | | | | | | DUE TO (c) Chronic Mental Disease | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 45 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt fell in the stool room of this Hospital from syncope | | | | | |
| 20c. TIME OF INJURY Hour 8:00 a. m. PM 5-28-57 Year 57 | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office, etc.) State Hospital #3 | | 20f. CITY, TOWN, OR LOCATION Nevada COUNTY Vernon STATE Missouri | | | |
| 21. I attended the deceased from March 21, 1957 to March 28 1957 and last saw her alive on March 28, 1957 Death occurred at March 28, 1957 11:05 PM the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Paul D. Myers M.D. | | | | 22b. ADDRESS State Hospital No. 3 | | 22c. DATE SIGNED March 28, 1957 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE March 28-57 | | 23c. NAME OF CEMETERY OR CREMATORY Conie De Loen | | 23d. LOCATION (City, town, or county) (State) Conie, Mo. | |
| 24. FUNERAL DIRECTOR Harrier Funeral Home - Claver, Mo. | | ADDRESS 4-4-1957 | | 25. DATE RECD. BY LOCAL REG. 4-4-1957 | | 26. REGISTRAR'S SIGNATURE Anna E. Ferry | |

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
Signature of Student Embalmer

Signed

Percy F. Melister

Licensed Embalmer No. *480*

P. O. Address *Nevada, 1*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.