

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-024885**

FILED VS JUL 27 1959 33

83

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harrison.</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ridgeway</u> Length of stay in lb <u>5 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Daughters Home N Ridgeway</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Harrison</u> c. CITY OR TOWN <u>Ridgeway</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Eva Irene Thorp.</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>7-17-59</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-20-72</u>		<b>9. AGE (last birthday)</b> <u>86</u>		<b>IF UNDER 1 YEAR</b> Months <u>10</u> Days <u>23</u>		<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>keeper own home</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>house work.</u>				<b>11. BIRTHPLACE</b> (City and state or country) <u>Cassville Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>			
<b>13a. FATHER'S NAME</b> <u>William R. Noble</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>Nancy C. Spelman</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>John Thorp, deceased</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>No</u>				<b>17. INFORMANT</b> Address <u>Josie Provin, Ridgeway Mo</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> DUE TO (b) <u>Hypertensive Heart Disease</u> <u>10 years</u> DUE TO (c) <u>Cardio-Vascular*Renal Disease</u> <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>---</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>---</u>									
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year -----		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>											
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) -----				<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE -----									
<b>21. I attended the deceased from</b> <u>2/2/58</u> <b>to</b> <u>7/17/59</u> <b>and last saw her alive on</b> <u>7/1/59</u> <b>Death occurred at</b> <u>8 P.M. 7-17-59</u> <b>on the date stated above, and to the best of my knowledge, from the causes stated.</b>													
<b>22a. SIGNATURE</b> (Degree or title) <u>Bernie Courtney, D.O.,</u>						<b>22b. ADDRESS</b> <u>Bethany, Missouri</u>			<b>22c. DATE SIGNED</b> <u>7/20/59</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>7-19-59</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ridgeway Cemetery</u>				<b>23d. LOCATION</b> (City, town, or county) (State) <u>1/2 m. W. Ridgeway Mo</u>					
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Robert R. Baggers, Ridgeway Mo</u>						<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-20-1959</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Jella Mayer</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6937 2. 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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert R. Rogers.

Licensed Embalmer No. 3576

P. O. Address Ridgeway

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.