

Dept. Health,
uc., & Welfare
U. S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-036452

STATE FILE NUMBER
4935

FILED VS OCT 23 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

V. S. 300
Rev. 1-57

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, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hosp.		Length of stay in 1b 8 days	d. STREET ADDRESS (If outside, give location) 609 A Orville Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DR. SARAH ELLEN THORP			4. DATE OF DEATH Month Day Year 10 12, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1877	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY D.O.	11. BIRTHPLACE (City and state or country) Lucerne, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Warren Howard		13b. MOTHER'S MAIDEN NAME Ellen Smith		14. NAME OF HUSBAND OR WIFE (Deceased) Thomas Mitchell Thorp	
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 Address Gladye Ellen Helton, niece, 811 north 9th st. K.C.K.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute circulatory Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200					INTERVAL BETWEEN ONSET AND DEATH Minutes 10 Months years
20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 10/4/59 to 10/12/59 and last saw her ^{her} alive on 10/12/59 Death occurred at 8:25 p m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Milton S. Steinberg MD		22b. ADDRESS 926 E. 11 St. K.C. Mo		22c. DATE SIGNED 10/13/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 10/15/1959	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.		23d. LOCATION (City, town, or county) (State) Weston, MO.
24. FUNERAL DIRECTOR WERNER MORTUARY		ADDRESS K.C.K.	25. DATE RECD. BY LOCAL REG. 10-13-59		26. REGISTRAR'S SIGNATURE Meva Minshall

Milton S. Steinberg SE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

securing the medical certification in the specific manner required by 193.140 MoRS 1949. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr. S. G. ... 21-1444
City of ...
118 ...

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 *Joseph M. ...*

Licensed Embalmer No. *5007*

P. O. Address *Lawrence, Kansas*

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.