DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

S JUL 18 1960

60-026412
STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 160

1. PLACE OF DEATH a. COUNTY Franklin	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Franklin
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington — Length of stay in 1b 3 years	c. CITY OR TOWN Washington — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Francis Hosp. — Inside Limits Yes X No ☐	d. STREET ADDRESS (If outside, give location) 549 East Sixth St. — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print)	First JAMES	Middle MARTIN	Last THARPE	4. DATE OF DEATH Month July Day 10, Year 1960
5. SEX M	6. COLOR OR RACE White	7. Married ☐ Never Married ☐ Widowed XX Divorced ☐	8. DATE OF BIRTH 10/7/1879	9. AGE (last birthday) 80 — IF UNDER 1 YEAR Months 9 Days 3 — IF UNDER 24 HR Hours – Min. –
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker	10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (City and state or country) Aud Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Thomas Tharp	13b. MOTHER'S MAIDEN NAME Amamda Coffelt	14. NAME OF HUSBAND OR WIFE Leatha, nee Richardson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 489-16-3797	17. INFORMANT Mrs Earl Gephardt, Address 549 E. 6th St Washington, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Thrombosis	2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	5+ years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1956, to July 10, 1960 and last saw ~~her~~ him alive on July 10, 1960

Death occurred at 10:55 p.m. CST m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John B Ryan MD	22b. ADDRESS Washington, Mo	22c. DATE SIGNED 7-11-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 13, 1960	23c. NAME OF CEMETERY OR CREMATORY Shirley Cemetery	23d. LOCATION (City, town, or county) (State) Osage Cy. near Linn, Mo.
24. FUNERAL DIRECTOR ADDRESS Henry W. Otto, Washington, Mo.	25. DATE RECD. BY LOCAL REG. 7/11/60	26. REGISTRAR'S SIGNATURE [signature]	

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Henry W. Ot

Signature of Student Embalmer

Licensed Embalmer No. 350

P. O. Address Washin

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