

Registration District No. 124

Primary Registration District No. 3009

Registrar's No. 179

## 1. PLACE OF DEATH:

- (a) County Cape Girardeau  
 (b) City or town Cape Girardeau  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St Francis Hosp: O  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
 (Specify whether  
 In this community 20 years  
 years, months or days)

8. (a) PRINT FULL NAME Bessie Mabel Tharp3. (b) If veteran, name war  3. (c) Social Security No. 

4. Sex female 5. Color or race white 6. (a)  Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Joseph W Tharp 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Aug. 22 1901  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
39 8 11 hr. min.9. Birthplace Scott Co Mo  
 (City, town, or county) (State or foreign country)10. Usual occupation housewife11. Industry or business 

- MOTHER FATHER  
 12. Name Norval Goodard  
 13. Birthplace Scott Co Mo  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Hillie Jehlen  
 15. Birthplace Scott Co Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Norval Goodard  
 (b) Address Commerce Mo17. (a) Burial (b) Date thereof May 5 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Oakdale Cem Commerce Mo18. (a) Signature of funeral director Bert Ingram  
 (b) Address Illmo Mo19. (a) 5-3-41 (b) Jon Thompson  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Scott  
 (c) City or town Illmo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 3  
 year 41 hour 8 minute 45 P. M.21. I hereby certify that I attended the deceased from  
5/1, 1941 to 5/3, 1941;  
 that I last saw her alive on 5/3, 1941;  
 and that death occurred on the date and hour stated above.Immediate cause of death Intestinal Obstruction Duration \_\_\_\_\_Due to Post Operative  
AdhesionsDue to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

## 22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) no  
 (b) Date of occurrence   
 (c) Where did injury occur?  (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address Cape Girardeau Mo Date signed 5/3/41

12312

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Mamie Duplenghoff

Licensed Embalmer No. 3242

P.O. Address Chaffee, m

**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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19724

Registration District No. 125

Primary Registration District No. 2009

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Beattie Mabel Thayer  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
39 8 11 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 3  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death

Intestinal obstruction

Due to Post operative adhesions

Due to Appendectomy & uterine suspension 1922

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 1228

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature H. W. Thayer (M. D. or other) MD

Address Cape Girardeau Date signed 7-17-41

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

19724