DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 15 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25878

Registration District No. 330 Primary Registration District No. 3074 Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston (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 1 (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town 100 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Gary Wayne Throop

3. (b) If veteran, name war ^ 3. (c) Social Security No. ^

4. Sex M O 5. Color or race W 6. (a) Single, widowed, married, divorced X 0

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

7. Birth date of deceased 2 (Month) 15 (Day) 1943 (Year)

8. AGE: Years 1 Months 3 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Carl Throop
13. Birthplace Clarksville (City, town, or county) Ark (State or foreign country)

MOTHER
14. Maiden name Virgie Jones
15. Birthplace Randles (City, town, or county) MO (State or foreign country)

16. (a) Informant Mark Throop Throop

(b) Address 403 No. Ad. Sikeston Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-44 (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo

18. (a) Signature of funeral director H. W. Albretton

(b) Address Sikeston Mo

19. (a) 8/6/44 (Date received local registrar) (b) Louie Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 3 year 1944 hour 11 minute 00 P M.

21. I hereby certify that I attended the deceased from June 3, 1944, to June 3, 1944, that I last saw him alive on June 3, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Meningitis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C J Nienstedt (M. D. or other)

Address Box F Sikeston Mo Date signed 4/5/44

1318

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 844-1
Date Filed 8-10-44

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 John Allerton

Licensed Embalmer No. 2941

P. O. Address Selkeston

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

AUG 15 194

State File No. ____

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. ____

1. PLACE OF DEATH:
(a) County: Scott
(b) City or town: Sikeston
(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 years, months or days)
In this community ____

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 ____

3. (a) PRINT FULL NAME: Gary W. Throop
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Feb. (Month) 15 (Day) 1943 (Year)
8. AGE: Years 1 Months 3 Days 8 If less than one day: hr. ____ min.
9. Birthplace: ____ (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Child
11. Industry or business: None
12. FATHER Name ____
13. FATHER Birthplace ____ (City, town, or county) ____ (State or foreign country)
14. MOTHER Maiden name ____
15. MOTHER 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) Laura Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June year 1944 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from ____, 19____ to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Meningitis

Due to: This was not epidemic

Due to: Meningitis

Other conditions (Include pregnancy within 3 months of death): ____

Major findings:
Of operations: 8/a
Of autopsy: ____

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature E. J. Neinstedt (M. D. or other) M.D.
Address Sikeston, Mo Date signed ____

SUPPLEMENTARY

25878