

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6752
Registrar's No. 1615

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| c. LENGTH OF STAY (In this place) 0 weeks | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Pacific Hospital | | d. STREET ADDRESS (If rural, give location) 2153 Stansbury | |

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|--|------------------------|--|--------------------------------|---|------------------------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | |
| a. (First) OGDEN | b. (Middle) HOFFMAN | c. (Last) THORPE | (Month) 2 | (Day) 19 | (Year) 1949 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH Oct. 17, 1872 | 9. AGE (In years last birthday) 76 | 10. UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) St. Louis, Missouri | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Dorothy | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT'S SIGNATURE OR NAME Blanche Buchanan--2153 Stansbury | |

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| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
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|---|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, embolism, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage 1st attack Dec '48 2nd Feb 11 '49 ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardio Vascular Disease 930 DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1st 2nd Anemia 1 wk | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |

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|---|--|---|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

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|--|--|--|--|--|--|
| 23a. SIGNATURE Blanche Buchanan M.D. | | 23b. ADDRESS Mo. Pac. Hosp | | 23c. DATE SIGNED 2/19/49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 2/21/49 | | 24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery | |
| 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri | | 25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldrich 3634 Gravois | | | |

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|---|--|---------------------------------------|--|-------------------------|--|
| DATE REC'D BY LOCAL REG. FEB 21 1949 | | REGISTRAR'S SIGNATURE J. B. Sauter | | ADDRESS 3634 Gravois | |
|---|--|---------------------------------------|--|-------------------------|--|

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
Student Embalmer

Signed

Robert Wheeler

Licensed Embalmer No. *2178*

P. O. Address *St Louis Mo*

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, fact should be so stated above.