

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39368

State File No. 9804

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No.

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 ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, 0		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLAYTON	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL		d. STREET ADDRESS (If rural, give location) # 121 N. Hanley Road.	
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) REEVES c. (Last) THROOP.		4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1949	
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 24, 1882
9. AGE (In years last birthday) 67		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Instructor; Washington U.		11. BIRTHPLACE (State or foreign country) Boydsville, Kentucky /	
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME George Reeves Throop.		13b. MOTHER'S MAIDEN NAME Althea Edwards.	
14. NAME OF HUSBAND OR WIFE Esther Fellows Throop.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, specify unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Northcutt Coll.		ADDRESS 6374 Clayton Road.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive Cardio Vasc Dis 10 yrs	
19a. DATE OF OPERATION none		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 5/10			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 177X			
22. I hereby certify that I attended the deceased from April 19 49 to Nov 11, 19 49 that I last saw the deceased alive on Nov 11, 19 49 and that death occurred at 11:15 P.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Paul O. Hagemann M.D.		23b. ADDRESS 3720 Washington	
23c. DATE SIGNED 11-12-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 11/14/1949	
24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. NOV 14 1949		REGISTRAR'S SIGNATURE J. B. Lasater	
25. FUNERAL DIRECTOR'S SIGNATURE G.R. Lupton & Sons; 7233 Delmar Blvd.		ADDRESS	

7086

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**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.....

working under my personal supervision.

Student Embalmer No. ....

Student .....  
Student Embalmer

Signed *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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.