

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4388**
Registrar's No. **0240**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500**

FILED JAN 31 1953

1. PLACE OF DEATH a. COUNTY St. Louis, 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 Manchester, Mo.		c. LENGTH OF STAY (In this place) 10 mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Crest Nursing Home		d. STREET ADDRESS (If rural, give location) Unknown	

3. NAME OF DECEASED (Type or Print) a. (First) Cyrus b. (Middle) _____ c. (Last) Thorpe			4. DATE OF DEATH Jan. 22/53 (Month) (Day) (Year)		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH May 2/1883	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed Unit		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME William Thorpe	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Nellie
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 492-01-510	17. INFORMANT'S SIGNATURE OR NAME Viola Woelfert	ADDRESS --2808 Shenandoah
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac Dilatation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Paralytic agitator		1 yr	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 4222	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **4-3-53**, to **1-22**, 19**53**, that I last saw the deceased alive on **1-22**, 19**53**, and that death occurred at **9:40p** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) _____	23b. ADDRESS Linwood v. mo	23c. DATE SIGNED 1-23-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/24/53	24c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. 1-23-53	REGISTRAR'S SIGNATURE Herbert R. Danks	25. FUNERAL DIRECTOR'S SIGNATURE W. P. Vacker-Welderle	ADDRESS 3634 Gravois
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10.300
0.48

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.