

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34800

State File No.

No. 300
10.48

FILED OCT 1 - 1953

1050

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

BIRTH NO.		REG. DIST. NO. <u>349</u>		PRIMARY REG. DIST. NO. <u>4514</u>		Registrar's No. <u>17</u>	
1. PLACE OF DEATH a. COUNTY Sullivan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Sullivan			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Green City		c. LENGTH OF STAY (in this place) 1 1/2 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Green City		1050 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home in Green City				d. STREET ADDRESS (If rural, give location) No street address			
3. NAME OF DECEASED (Type or Print) a. (First) America		b. (Middle) Shipley		c. (Last) Tharp		4. DATE OF DEATH (Month) (Day) (Year) Sept. 11, 1953	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Sept. 5, 1863	
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Farm home		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Samuel Shipley Page			13b. MOTHER'S MAIDEN NAME Elizabeth Payne			14. NAME OF HUSBAND OR WIFE Calvin Tharp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y. no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Anna Beall, Green City, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 8 days	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		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 <u>Nov. 12, 1952</u> , to <u>Sept 11, 1953</u> , that I last saw the deceased alive on <u>Sept 11, 1953</u> , and that death occurred at <u>6:55 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE R.D. Smith M.D. (Degree or title)				23b. ADDRESS Green City Mo.		23c. DATE SIGNED 10/14/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sept. 14, 1953		24c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		24d. LOCATION (City, town, or county) (State) Sullivan County, Mo.	
DATE REC'D BY LOCAL REG. Sept. 29, 1953		REGISTRAR'S SIGNATURE Annabella D. Cooper, deputy		25. FUNERAL DIRECTOR'S SIGNATURE Henry E. Kent		ADDRESS Green City, Mo.	

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, 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.