

FILED JAN 25 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3431**  
Registrar's No. **53**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Koch</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place) <b>5 1/2 mo</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>4811 EASTON 2069</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>DORA</b>	b. (Middle) <b>Mildred</b>	c. (Last) <b>THARP</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>1-6-56</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>7-12-79</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>1-RT. home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Pulaski County, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Lynch</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Parker</b>	14. NAME OF HUSBAND OR WIFE <b>George Tharp</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Records</b>	ADDRESS <b>Robert Koch Hospital</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>unk now</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b>		
	II. OTHER SIGNIFICANT CONDITIONS. <b>1. Bronchietasis</b> <b>2. Pulmonary tuberculosis, FA, No Clinical Activity</b>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-26**, 19**55**, to **1-6**, 19**56**, that I last saw the deceased alive on **1-6**, 19**56**, and that death occurred at **5:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Axel R. Brown M.D.</b>	23b. ADDRESS <b>Robert Koch Hospital</b>	23c. DATE SIGNED <b>1-6-56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1-9-56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, MO</b>
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DATE REC'D BY LOCAL REG. <b>1-7-56</b>	REGISTRAR'S SIGNATURE <b>Dorbert B. Dombert MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Cullinane Bros</b>	ADDRESS <b>33201 Kings Highway St. Louis, MO</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....  
Signature of Student Embalmer

Signed *Will C. Branson*.....

Licensed Embalmer No. *470*.....

P. O. Address *St. Louis*.....

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 embalmed by a **STUDENT**, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.