

FILED JAN 27 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **995**
 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 69A

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If outside, give location) 1850 S. Virginia	
3. NAME OF DECEASED (Type or print) First BEALOR Middle R. Last THARP		4. DATE OF DEATH Month January Day 19 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Dec. 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dentist	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME Charles C. Tharp		13b. MOTHER'S MAIDEN NAME Mary Coons	14. NAME OF HUSBAND OR WIFE Chloe Tharp
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, if unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion, myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 6 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerotic heart disease			unknown
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Springfield, Missouri	
21. I attended the deceased from 1/18/58 to 1-19-58 and last saw her alive on 1/19/58 Death occurred at 2:40 A m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>[Signature]</i>	
22b. ADDRESS Springfield, Missouri		22c. DATE SIGNED 1/24/58	
23a. BURIAL, CREMATION, REBURYAL (Specify) Burial	23b. DATE 1-22-58	23c. NAME OF CEMETERY OR CREMATORY Greenlawn	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
24. FUNERAL DIRECTOR J.W. Klingner & Co. Spgfd. Mo.		25. DATE RECD. BY LOCAL REG. 1-24-58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUL 28 1958

MS MAY 26 1957

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 *Glen D. Williams*

Licensed Embalmer No. *4657*

P. O. Address *Springfield*

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.