

Dr. Lurie

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017410

STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 565

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 511 S. BROADWAY			Length of stay in lb 27 YRS.		d. STREET ADDRESS (If outside, give location) 511 S. BROADWAY		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZA Middle JANE Last THARP				4. DATE OF DEATH Month JUNE Day 7 Year 1959				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 3 1869		9. AGE (In years) 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) HOME			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) OREGON COUNTY, MO.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME JONES			13b. MOTHER'S MAIDEN NAME UNKNOWN			14. NAME OF HUSBAND OR WIFE CHAS. H. THARP (DEC.)		
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. NO		17. INFORMANT Address L.C. THARP OKLAHOMA CITY, OKLA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia							INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) Arteriosclerotic Heart Disease				Several years	
			DUE TO (c) Generalized Arteriosclerosis A280				" "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Arteriosclerosis + Hypertension							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Hour _____ a.m. _____ p.m.								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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		COUNTY		STATE
21. I attended the deceased from <u>1-23-56</u> , to <u>6-7-59</u> and last saw her/him alive on <u>6-7-59</u> Death occurred at <u>9:30 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deceased or title) Harold H. Lurie, M.D.				22b. ADDRESS 609 Cherry Springfield, Mo			22c. DATE SIGNED 6-8-59	
23a. BURIAL, CREMATION, (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)		
BURIAL		6/10/59	MAPLE PARK			SPRINGFIELD, MO.		
24. FUNERAL DIRECTOR H.H. LOHMEYER			ADDRESS SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 6-10-59		26. REGISTRAR'S SIGNATURE Effie G. Melton	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *W. L. McCowan*

Licensed Embalmer No. *2727*

P. O. Address *Spangher, Pa.*

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.