

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025259

6632

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED JUL 12 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1	
2	205
3	
4	1
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12	52-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
ST. LOUIS, MISSOURI		St. Louis		54-yrs.	Mo.			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits	d. STREET ADDRESS (If outside, give location)			Reside on Farm
BARNES HOSPITAL				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	5918 Waterman Ave.			Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		
GERTRUDE			C.	THORPE		JULY 3, 1962		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR	
F.	W.		5/10/1882	80	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state and country)		12. CITIZEN OF WHAT COUNTRY	
Housewife					Toledo, Ohio		U.S.	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE		
Patrick Joseph Conroy			Ann O'Connell			Mr. George L. Thorpe		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address			
no					Mrs. Fred R. Ramsen, 726 Berick Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THORACIC CAVITY, PRIMARY SITE UNKNOWN								
DUE TO (b) 165X								
DUE TO (c) 165X								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days.		
						<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
Hour a.m. p.m.		Month, Day, Year						
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 JANUARY 20, 1962 to JULY 3, 1962 and last saw her/him alive on JULY 3, 1962 Death occurred at 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title)					22b. ADDRESS		22c. DATE SIGNED	
<i>E. D. Vermillion, M.D.</i> M.D.					BARNES HOSPITAL		7/5/62	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
Burial		7/6/1962	Calvary Cemetery		St. Louis, Missouri			
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY REG.		26. REGISTRAR'S SIGNATURE		
<i>Arthur J. Donnell</i> 810 Lindell Blvd.				JUL 5 1962		<i>Earl Smith, M.D.</i>		

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  _____

Licensed Embalmer No. 4689

P. O. Address 3840 Leland

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.