

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-039126

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 499

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 24 1962

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u> Length of stay in 1b <u>1 day</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Independence Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> c. CITY OR TOWN <u>Liberty</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>937 Manchester</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>O.</u> Last <u>Throop</u>			4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1962</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-98</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired hotel clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Charles T. Drury</u>		13b. MOTHER'S MAIDEN NAME <u>Ella V. Buzzard</u>	
14. NAME OF HUSBAND OR WIFE <u>Ralph A. Throop</u>			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address <u>Lovella Clark Liberty, Missouri</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal Hemorrhage</u> DUE TO (b) <u>Gall Bladder Carcinoma & metastases</u> DUE TO (c) <u>!</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>6 wk.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Memoria</u>	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from 1960 to 10-17-62 and last saw him alive on 10-17-62
 Death occurred at 6:28 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William Lox MD</u>	22b. ADDRESS <u>Liberty Mo</u>	22c. DATE SIGNED <u>10-18-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>10-20-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hominy Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hominy, Oklahoma</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Pasley Funeral Home Liberty, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-19 62</u>	26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u>
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 7005
 26003
 3
 4 1
 5 2
 6
 7 0
 8 2
 9 1551
 10
 11
 12 1-0
 13 1-0
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

OCT 25 1962

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 John Pasley

Licensed Embalmer No. 4308

P. O. Address Liberty, Md.

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.

10-19-62