

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County North
Township Quinn
or
Village
or
City Panama Mo (NO. _____ St. _____ Ward _____)

Registration District No. 1057

File No. 19360

Primary Registration District No. 6274

Registered No. _____

FULL NAME

Emley Jane Thacker

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>Nov. 10</u> , 18 <u>26</u> (Month) (Day) (Year)		
AGE <u>91</u> yrs. <u>7</u> mos. <u>14</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Domestic</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Indiana</u>		
PARENTS	NAME OF FATHER <u>Benjamin Sloan</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Indiana</u>	
	MAIDEN NAME OF MOTHER <u>Mary Davis</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O D Herndon
(ADDRESS) Panama Mo

Filed July 16, 1918
S T M Cox REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 24, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 12, 1918, to May 23, 1918, that I last saw her alive on May 23, 1918, and that death occurred, on the date stated above, at 7.2 m.

The CAUSE OF DEATH* was as follows:

Cardiac Stenosis (Aortic Disease)
92A
95679
160 (Duration) _____ yrs. _____ mos. _____ ds.
Contributory Old age
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L O Myer M. D.
July 13, 1918 (Address) Panama

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Balesville Indiana DATE OF BURIAL May 26, 1918
UNDERTAKER Prof LaFaro ADDRESS Panama Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

County.....

Township.....
orVillage.....
or

City..... (NO.

Registration District No.

File No.

Primary Registration District No.

Registered No.

St. Ward)

(If death occurred in a
hospital or institution,
give its NAME instead
of street and number.)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX..... COLOR OR RACE.....
SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If fit the word)

DATE OF BIRTH

(Month)..... (Day)....., 191..... (Year)

AGE

IF LESS than
1 day,..... hrs.
or..... min.?

OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

BIRTHPLACE

(City or town,
State or foreign country)NAME OF
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month)....., 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h..... alive on....., 191.....

and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

(Duration)..... yrs. mos. ds.

Contributory

(SECONDARY)

(Duration)..... yrs. mos. ds.

(Signed)

M. D.

(Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS)At place
of death..... yrs. mos. ds. In the
State..... yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS