

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

Do not use this space.

9407

1. PLACE OF DEATH

County Jasper Registration District No. 411 File No. _____
 Township Poplar Primary Registration District No. 2002 Registered No. 168
 City Poplar No. _____ St. _____ Ward _____

2. FULL NAME

Billie Jane Thatcher
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 1 - 28

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
 _____ | _____ | 25 | _____

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Poplar
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER W. L. Thatcher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Col
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Junita Sawyer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
 (STATE OR COUNTRY) _____

14. INFORMANT G. P. Thatcher
 (Address) Poplar Mo

15. FILED 37 19 28 W. A. Benson REGISTRAR
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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 26 19 28

17. I HEREBY CERTIFY That I attended deceased from Mar 26 19 28 to Mar 26 19 28
 that I last saw h. live on Mar 26 19 28 and that death occurred, on the date stated above, at 4:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial pneumonia

CONTRIBUTORY (SECONDARY) flu (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED HA
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Ray Myers, M. D.

(Address) Poplar Mo

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Park DATE OF BURIAL 3-27-19 28

20. UNDERTAKER Hubbards Co ADDRESS Poplar Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

