

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

Do not use this space.

32202

NOV 21 1930

1. PLACE OF DEATH

County Buchanan
Township _____
City St. Joseph

Registration District No. 355
Primary Registration District No. 100
(No. St. Joseph's Hospital)

File No. _____
Registered No. 1160
St. _____ Ward _____

2. FULL NAME

Jess William Thresher

(a) Residence. No. 3132 Burnside Ave. St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Myrtle Thresher

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb, 2, 1881

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>49</u>	<u>8</u>	<u>21</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Mechanic, St. Railway
(b) General nature of industry, business, or establishment in which employed (or employer) Power House.
(c) Name of employer St. Jos. St. R.R. Co.

9. BIRTHPLACE (CITY OR TOWN) Stanberry, Mo.
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>John Thresher</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Owen Co, Ind.</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT Mrs. Myrtle Thresher
(Address) 3132 Burnside Ave.

15. FILED 1930
John G. [Signature]
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct, 23, 1930 19

17. I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1930, to Oct. 23, 1930.
that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 11.55 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Thrombotic angina obliterans
Raymonds Disease
97B
11.55
9.00 (duration) _____ yrs. mos. ds.
CONTRIBUTORY Respiratory Paralysis
(SECONDARY) (duration) _____ yrs. mos. ds.

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

2 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Oct. 23, 30
WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Phys. Exam - Lab. Tests
(Signed) J. H. Thompson M. D.

10/23/1930 (Address) 825 Charles St. Joseph, 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 <u>Mt. Auburn Cemetery</u>	DATE OF BURIAL <u>Oct, 25, 1930</u>
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20. UNDERTAKER <u>Walter Meischoff</u>	ADDRESS <u>1302 Faraon St.</u>
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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.

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