

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
JACKSON
 (a) County **KANSAS CITY MO.**
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **NORTHEAST HOSPITAL**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **three days**
 (Specify whether
 In this community **on a visit from Indiana**
 years, months or days)

8. (a) PRINT FULL NAME **Cyrus D. Thatcher**
8. (b) If veteran, **No** **name war**
8. (c) Social Security No. **No**

4. Sex **Male** **5. Color or race** **wh** **6. (a) Single, widowed, married, divorced** **wid.**
6. (b) Name of husband or wife **Unknown** **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **Oct 11 1857**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	82	11	21	hr. _____ min.

9. Birthplace **Indiana**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
12. Name **Mr. John Thatcher**
13. Birthplace **Ind.**
 (City, town, or county) (State or foreign country)
14. Maiden name **Miss Fischer**
15. Birthplace **Indiana**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Frank Meyers**
(b) Address **Buckner Missouri**

17. (a) Burial **Oct 5 1940** **(b) Date thereof** **Oct. 8 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Buckner Cemetery**

18. (a) Signature of funeral director **J. M. Reppert**

(b) Address **Buckner Mo**

19. (a) 10-3-40 **(b) M. M. Brown**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Indiana** (b) County _____
 (c) City or town **Frankfort**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **2**
 year **1940** hour **4** minute **40 AM** M.

21. I hereby certify that I attended the deceased from **Sept.**
 _____, 19**40**, to **Oct 2**, 19**40**;
 that I last saw him alive on **Oct**, 19**40**

and that death occurred on the date and hour stated above.
 Immediate cause of death **Hypostatic pneumonia**

Due to **myocardial degeneration**

Due to **prostatic surgery for Bony retention**

Other conditions. (Include pregnancy within 3 months of death) **137**

PHYSICIAN
 Major findings: _____
 Of operations: _____
 Of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

 (Specify type of place) (e) Means of injury _____

23. Signature **J. W. Higgins** (M. D. or other) **D.O.**
Address **Buckner Ind** **Date signed** **10/2/40**

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 XX

~~Registered Apprentice~~
working under my personal supervision.

Signed *D. M. Reppert*

Licensed Embalmer No. 2321

P. O. Address Buckner Mo.

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No. 3833

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Cyrus D. Thatcher

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Male 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10/3/40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits write "RURAL")
(d) Street No.....
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

DECLARATION OF DEATH

20. DATE OF DEATH: Month Oct day 2
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Degeneration
Prostatic Hypertrophy
Pneumonia

Due to.....

Due to..... Prostatic Surgery 9/30/40

Other conditions: complete retention of urine
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy..... 137

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

..... (Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

S-34317