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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22335

FILED JUL 8 1944
Registration District No. 298

Primary Registration District No. 604

State File No. _____
Registrar's No. 8

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Rural
(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 1
(Specify whether years, months or days)
In this community About 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Ray
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Thalls
3. (b) If veteran, name war no
3. (c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 9
year 1944 hour 8 AM minute _____ M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 30 1856
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1938, to June 9 1944
that I last saw him alive on May 10 1944
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
88 4 9 hr. _____ min.

Immediate cause of death
Sudden Arteriosclerosis
Chronic Myocarditis
Cardiac Failure

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

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 93d

10. Usual occupation farmer

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Mrs Jennie Mayes

(b) Address Lawson, Mo. R. R.

17. (a) Burial (b) Date thereof (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation Elmwood cemetery, Kansas City, Mo.

18. (a) Signature of funeral director Charles A. Shaw

(b) Address Excelsior Springs, Mo.

19. (a) June 9, 44 (b) W. H. Reed
(Date received local registrar) (Registrar's signature)

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? _____

While at work? (Specify type of place) (e) Means of injury _____
23. Signature John E. Buchner (M. D. or other) _____
Address Lawson Mo Date signed June 9, 1944

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

MOTHER FATHER

114 S

RECEIVED

District Health Officer No. 8,

District File No.

Date Filed

7-2-77

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Claudio Richard

Licensed Embalmer No. *2751*

P. O. Address.....

Exelsior Spn

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *July*

July 8

Registration District No. *298*

Primary Registration District No. *6024*

Registrar's No. *8*

1. PLACE OF DEATH:

(a) County *Ray*
(b) City or town *Boonville* (If outside city or town limits, write "RURAL" and name of township) *Poesh*
(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 *Wm Thalh*

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

4. Sex *SM* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *W*

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

7. Birth date of deceased *Jan 30 1954* (Month) (Day) (Year)

8. AGE: Years *88* Months *4* Days *20* If less than one day, min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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) Citizen of foreign country? (Yes or No) If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* 19*54* year *1954* hour *10* minute *00* M.

21. I hereby certify that I attended the deceased from *1954* to *1954* that I last saw him *alive* on *July 8* and that death occurred on the date and hour stated above. Immediate cause of death *Heart Failure*

Duration

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

MOTHER FATHER

22335