

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 5 1946 Registration District No. 254

Primary Registration District No. 5867 Registrar's No.

1. PLACE OF DEATH: (a) County Oregon (b) City or town Thayer (Rural) (c) Name of hospital or institution: (d) Length of stay: In hospital or institution 17 years

2. USUAL RESIDENCE OF DECEASED: (a) State Missouri (b) County Oregon (c) City or town Thayer (Rural) (d) Street No. (e) Citizen of foreign country? No

3. (a) PRINT FULL NAME William Allen Thomas (b) If veteran, name war: -- (c) Social Security No.

MEDICAL CERTIFICATION 20. DATE OF DEATH: Month Oct. day 8 year 1945 hour 10 minute 00 P. M. 21. I hereby certify that I attended the deceased from that I last saw him alive on and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed (b) Name of husband or wife Allie Kennedy (c) Age of husband or wife if alive years 7. Birth date of deceased Feb. 2 1889

Immediate cause of death Valvular Heart Disease Duration

8. AGE: Years 56 Months 8 Days 6 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name P. A. Thomas 13. Birthplace Thomasville Missouri (City, town, or county) (State or foreign country)

14. Maiden name Amy Willard 15. Birthplace Thomasville Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Miss Matilda Thomas (b) Address Mt. Vernon, Mo.

17. (a) Burial (b) Date thereof 10/19/45 (c) Place: burial or cremation Thayer Cem.

18. (a) Signature of funeral director Leo Carr Thayer, Mo. (b) Address Thayer, Mo.

19. (a) (Date received local registrar) (b) Registrar's signature

Due to ... Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Of autopsy 92d 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? (d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature Leo Carr 3030 (M. D. or other) Address Thayer Mo Date signed Oct 12-45

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

RECEIVED

District Health Officer No 5,

District File Number 14617

Date Filed 1-2-46

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.....

..... Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

Registration District No. *254*

Primary Registration District No. *5867*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Oregon*
(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. _____ (Specify whether

In this community _____ years, months or days)

3. (a) PRINT FULL NAME *William Allen Thomas*

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

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

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

7. Birth date of deceased *Feb 2, 1889*
(Month) (Day) (Year)

8. AGE: Years *56* Months *6* Days *no* If less than one day _____ 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) _____ (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) *10/2/45* (Date received local registrar) (b) *(Mary Stahl)* (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 _____ Day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ at _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

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? _____

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

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

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

42029