

FILED SEP 5 1947

Registration District No. **257**

Primary Registration District No. **5867**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Thayer (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 Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon

(c) City or town Thayer (Rural)
(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 _____

3. (a) PRINT FULL NAME William Lafayette Janes

3. (b) If veteran, name war --

3. (c) Social Security No. --

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1947 hour 2 minute 00 P. M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Martha Spragus Janes

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased October 10 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 1 - 1947 to June 20 1947
that I last saw h _____ alive on June 20
and that death occurred on the date and hour stated above. 1947

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>9</u>	<u>5</u>	_____ hr. _____ min.

Immediate cause of death Obstruction of bowels

Due to Carcinoma Colon

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

10. Usual occupation Farmer and Carpenter

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

Major findings: _____

Of operations: _____

Of autopsy: _____

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)

PHYSICIAN

Underline the cause to which death should be charged statistically.

H. B. Hull

16. (a) Informant Zentz Janes

(b) Address Thayer, Mo.

17. (a) Burial (b) Date thereof 7/17/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fled stnt Hill Cem.

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? _____

18. (a) Signature of funeral director Edith Cress

(b) Address Thayer, Mo.

19. (a) Aug. 6, 1947 (b) Edith Cress
(Date received local registrar) (Registrar's signature)

23. Signature H. B. Hull (M. D. or other) _____

Address _____ Date signed 7/28/47

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

MOTHER FATHER

Hull

RC 10

Dis. No.

District No.

Date Filed

847467
8-30-47

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.