

No. 2  
-1/47  
-17-39

FILED OCT 29 1947  
Registration District No. 177

Primary Registration District No. 6076

Registrar's No. 2251

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jennings  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 7028 Paisley Dr. /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Jennings  
(If outside city or town limits, write "RURAL")

(d) Street No. 7028 Paisley Dr.  
(If rural, give location)

(e) Citizen of foreign country? None (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Michael F. Thabar

3. (b) If veteran, name war None

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 23,  
year 1947 hour 6:40 PM minute PM M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Kate Thabar nee Messmer

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased May 13, 1887  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 13 47 to Oct 23 47  
1947 to Oct 23 47 1947  
that I last saw him live on Oct 23 1947  
and that death occurred on the date and hour stated above.

Duration

8. AGE:

Years	Months	Days	If less than one day
<u>60</u>	<u>5</u>	<u>10</u>	hr. <u>4</u> min.

Immediate cause of death Chronic myocarditis

Due to Metastasis of Primary Carcinoma of Prostate Gland

Other conditions Prostate Gland removed Jan 1946 - Carcinoma  
(Include pregnancy within 3 months of death)

9. Birthplace Austria (City, town, or county) (State or foreign country) 4

10. Usual occupation

11. Industry or business

12. Name Michael Thabar

13. Birthplace Austria (City, town, or county) (State or foreign country) 1

14. Maiden name Theresa Schmidt

15. Birthplace Austria (City, town, or county) (State or foreign country) 4

PHYSICIAN

Major findings: None

Of operations

Of autopsy None

Underline the cause of which death should be charged statistically.

16. (a) Informant Mrs Kate Thabar

(b) Address 7028 Paisley Dr. Jennings, Mo

17. (a) Burial (b) Date thereof 10/27/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Math Hermann & Son, Inc.

(b) Address 2161 East Fair Ave

19. (a) 10-27-47 (b) Beulah Sherman  
(Date received local registrar) (Registrar's signature)

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

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

(b) Date of occurrence None

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None (Specify type of place)

While at work? None (e) Means of injury None

23. Signature M. F. Thabar (M. D. or other) 10/25-47

Address 2739 N. Grand Date signed

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

MOTHER FATHER

DEC 2 1949

OCT 31 1949

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 *Walter G. Burnley*  
Licensed Embalmer No. *4202*  
P. O. Address *St Louis 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, fact should be so stated above.

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

State File No.

Nov

2251

Registration District No.

317

Primary Registration District No.

6076

Registrar's No.

## 1. PLACE OF DEATH:

(a) County St Louis  
 (b) City or town Jennings  
 (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 NAMEMichael J. Thaler3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_

4. Sex

m5. Color or  
race w6. (a) Single, widowed, married,  
divorced m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ year

7. Birth date of deceased

May 13 1948  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

6055min.

9. Birthplace

(City, town, or county)

Austria  
(State or foreign country)

10. Usual occupation

11. Industry or business

Shalechord Chem

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 April day 23  
 year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?

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

36716

36716