

FILED NOV 8 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32668

State File No.

BIRTH NO. _____ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 4158 Registrar's No. 60

2300
4

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

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>DALLAS</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Buffalo</u>)		c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN <u>Buffalo</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Marshall Rest Home</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <u>Marshall Rest Home</u>		0300	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Dee Witte</u>	b. (Middle) <u>Ellis</u>	c. (Last) <u>Thayer</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>10-30-1955</u>
-------------------------------------	-----------------------------	--------------------------	-------------------------	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-26-1876</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>7</u> Min. _____
--------------------	-------------------------------	---	-----------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Michigan</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	--	--

13a. FATHER'S NAME <u>Galen Thayer</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Pass</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>John Parker</u> ADDRESS <u>Red Top, Mo.</u>
--	-------------------------------	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Terminal Pneumonia</u>		Months _____ Years _____
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Renal deficiency & arterio</u> DUE TO (c) <u>Hypertension Arterio Sclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Valvular Heart Disease</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from Oct 27, 1955, to Oct 30, 1955, 1955, that I last saw the deceased alive on Oct 30, 1955, and that death occurred at 9:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>G.P. Heineman MD</u> (Degree or title)	23b. ADDRESS <u>Buffalo Mo.</u>	23c. DATE SIGNED <u>10-31-55</u>
--	---------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-2-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Church Grove C.</u>	24d. LOCATION (City, town, or county) (State) <u>Dallas Co. Mo.</u>
---	----------------------------	---	---

DATE REC'D BY LOCAL REG. <u>11/5/55</u>	REGISTRAR'S SIGNATURE <u>Mrs. Grace Patricia</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Jones</u> ADDRESS <u>Buffalo, Mo.</u>
---	--	---

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Leonard Jones*.....

Licensed Embalmer No. *256*

P. O. Address *Buffalo*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.