

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43979

FILED JAN 15 1957

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

11556

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>North Carolina</u> COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Greensboro</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>				Length of stay in 1b		d. STREET ADDRESS <u>Route #3</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>W.</u> Last <u>THAYER</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1895</u>	
9. AGE (In years last birthday) <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Physician</u>		100. KIND OF BUSINESS OR INDUSTRY <u>Medical Doctor</u>		11. BIRTHPLACE (City and state or country) <u>Trinity, North Carolina</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Physician</u>		100. KIND OF BUSINESS OR INDUSTRY <u>Medical Doctor</u>		11. BIRTHPLACE (City and state or country) <u>Trinity, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Marcus Thayer</u>				14. MOTHER'S MAIDEN NAME <u>Arminta Gaddis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dr. Edna C. Thayer, Rt #3</u> Address <u>Greensboro, N. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 Months</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>	
						DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTOXICATION DUE TO DRUGS (APRESOLINE), suspected</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <u>November 14, 1956</u> <u>December 16, 1956</u> and last saw ^{her} _{him} alive on <u>Dec. 16, 1956</u> Death occurred at <u>10:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Walter S. Binder, M.D.</u>				22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>16 Dec. 56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Dec. 18, '56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gulford Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>High Point, North Carolina</u>	
24. FUNERAL DIRECTOR <u>Ambruster Mortuary, 6633 Clayton Rd.</u>				25. DATE RECD. BY LOCAL REG. <u>DEC 17 1956</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

mgs

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.....


Licensed Embalmer No. 47

P. O. Address M-J

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.