

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035905

FILED VS NOV 2 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 11268

ENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Greene</u>	a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>	Length of stay in 1b <u>2 yrs.</u>	c. CITY OR TOWN <u>Republic</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Foster's Rest Home</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Jimmy</u>	Middle	Last <u>Thayer</u>	4. DATE OF DEATH	Month <u>October</u>	Day <u>20</u>	Year <u>1959</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1870</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR. Days	IF UNDER 24 HR. Hours	IF UNDER 24 HR. Min.
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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 country) <u>Crawford Co., Penn.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>James C. Thayer</u>	13b. MOTHER'S MAIDEN NAME <u>Clarissa J. Holman</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Mrs. Mable Thayer</u>	Address <u>Republic, Mo.</u>
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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>Pneumonia, broncho</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)		
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>Hypertension moderate</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from <u>Jan. 10, 1959</u> to <u>Oct. 20, 59</u> and last saw ^{her} him live on <u>Oct. 20, 1959</u> Death occurred at <u>about 2:30 AM, 20 Oct 59</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>James S. Knabb, M.D.</u>	22b. ADDRESS <u>1630 N. Jefferson Springfield Mo.</u>	22c. DATE SIGNED <u>10/28/59</u>
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23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-22-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Billings, Missouri</u>
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24. FUNERAL DIRECTOR <u>W.B. Cantrell</u>	ADDRESS <u>Republic, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-29-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

William D. Coates

Licensed Embalmer No. 4820

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