

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR MAY 19 1940

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

**16432**  
Do not use this space.

1. PLACE OF DEATH

(a) County Crittch Registration District No. 908

(b) Township High Line Primary Registration District No. 6222 Registered No. 24

(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Irene Thayer

(a) Residence, No. Mountain Grove St. Mo. Rural  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A. Thayer

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 24-1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

76 11 26

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housekeeper

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

FATHER

13. NAME A. Irwin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

MOTHER

15. MAIDEN NAME Sarah Robiette

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) Mrs. Thayer

18. BURIAL (CREMATION OR REMOVAL) PLACE High Line Rd. DATE April 23 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Russell Barber

20. FILED 4-23 19 40 to Bertha Montgomery Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 20 19 40

22. I HEREBY CERTIFY, That I attended deceased from April 13 1940, to April 20 1940

I last saw h. or alive on April 20 1940. Death is said to have occurred on the date stated above, at 5 p. m.

The principal cause of death and related causes of importance were as follows:

Sirochia Carcinoma Intestine Date of onset \_\_\_\_\_

Other contributory causes of importance: Chronic Irritation from \_\_\_\_\_

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Name of operation None Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) W. A. Craig M. D. \_\_\_\_\_

(Address) St. Louis, Mo.

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RECEIVED

District Health Officer No. 6,

District File Number 540-1272

Date Filed MAY 9 1940

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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 Russell Barber  
Licensed Embalmer No. 3848

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, above space should be left blank.