

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26860**

Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **6756**

I. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City Sanitarium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 yr. 4 mo. 7 day  
(Specify whether years, months or days)  
In this community 31 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4448 Washington Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME HARLEY THACKER

8. (b) If veteran, name war NO 8. (c) Social Security No. NO

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cordella Thacker 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased January 4, 1891  
(Month) (Day) (Year)

8. AGE: Years 49 Months 7 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Attwell Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Telegrapher

11. Industry or business Western Union

12. Name Benjamin Thacker

13. Birthplace Unknown Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Etta Robinson

15. Birthplace Unknown Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant John Ladd

(b) Address 5400 Grand St

17. (a) Cremation (b) Date thereof 8-9-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place City Infirmary Crematory

18. (a) Signature of funeral director J. Ryan

(b) Address City Infirmary

19. (a) AUG 8 1940 (b) J. T. Bredeek  
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8  
year 1940 hour 9.40 minute A. M.

21. I hereby certify that I attended the deceased from July 1, 1939  
to Aug. 8, 1940, 19\_\_\_\_;  
that I last saw him alive on Aug. 8, 1940, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Paresia 7-1-39-x

Due to Uremia 8-5-40

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

Other conditions 83  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy YES

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) (f) Means of injury \_\_\_\_\_

23. Signature Paul T. Hartman (M. D. or other)  
Address 5300 Olive Date signed 8-8-40

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

MOTHER—FATHER

---

---

**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.....

Licensed Embalmer No.....

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.**