

Registration District No. **531** Primary Registration District No. **5722** Registrar's No. _____

1. PLACE OF DEATH: **Macon**
 (a) County _____
 (b) City or town **Rural - Valley township**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME **JOHN W. THAYER**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Siccie Thayer** 6. (c) Age of husband or wife if alive **52** years
 7. Birth date of deceased **April 21 - 1875**
 (Month) (Day) (Year)

8. AGE: Years **65** Months **8** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace **Macon Co. Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **S. P. Thayer**
 13. Birthplace **Maryland**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Harriet Seney**
 15. Birthplace **Macon Co. Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Siccie Thayer**
 (b) Address **Callan, Mo.**

17. (a) **Burial** (b) Date thereof **Jan. 9 - 1941**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hull**

18. (a) Signature of funeral director **Clyde M. Callan**
 (b) Address **Elmer, Mo.**

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Macon Co.**
 (c) City or town **Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Southeast of Elmer**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Jan.** day **8**
 year **1941** hour **12** minute **30** A.M.

21. I hereby certify that I attended the deceased from **Dec. 20**
 19**40**, to **Jan 8**, 19**41**;
 that I last saw him alive on **Jan 8**, 19**41**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cornary Thrombosis** **5 wks.**

Due to **Unknown condition**

Due to _____

Other conditions **94 W**
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of, operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

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?
474 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____

23. Signature **Harold D. Lewis** (M. D. or other) **DO**
 Address **Elmer Mo.** Date signed **1/10/41**

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

RECEIVED

District Health Officer No. 10

District File Number 3-44-621

Date Filed MAR 14 1947

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

Clyde M. Colburn

Licensed Embalmer No. 3226

P. O. Address Elmer, 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 this body is not embalmed, fact should be so stated above.

STATE OF MISSOURI - DEPARTMENT OF HEALTH - DIVISION OF PUBLIC HEALTH - ST. LOUIS, MO.

Registration District No. 531

Primary Registration District No. 5722 B

Registrar's No.

1. PLACE OF DEATH:

(a) County macon
(b) City or town Valley T. P.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME John W Thayer

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 18 If less than one day min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-1-1941 (Date received local registrar) (b) J. A. Steckler (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 8 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death.

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (e) Means of injury

23. Signature Harold D. Lehr (M. D. or other)

Address Elmer mo Date signed

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

SUPPLEMENTAL

