

REC'D APR 17 1939

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

9322
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Haver Primary Registration District No. 1002 Registered No. 928
 (c) City H.C. Mo (d) Street No. H.C. Gen Hosp 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

(a) Residence, No. 653 3507 Brooklyne St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ethel Thornton
Feb-16-1887
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
 7. AGE YEARS 55 MONTHS - DAYS 12 If LESS than 1 day, hrs. min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. H.C. Mo
 9. Industry or business in which work was done, as saw mill, bank, etc. Waste Dept
 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) Jaysa

FATHER 13. NAME Ephraim Thornton

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

MOTHER 15. MAIDEN NAME Alice Childs

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

17. INFORMANT (ADDRESS) Record Clerk H.C. Gen Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Laverne Kans DATE Mar 2 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mr C.B. Forster Kansas City Mo

20. FILED 3-1 1939 M.M. Crouse Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-28-39, 19
 22. I HEREBY CERTIFY, That I attended deceased from 2-4-39, 19, to 2-28-39, 19.
 I last saw him/her live on 2-28-39, 19. Death is said to have occurred on the date stated above, at 6:10 p.m.
 The principal cause of death and related causes of importance were as follows:

Brain Abscess
1750
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? Yes

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) P. P. De Marn M. D.
Dept H.C. Gen Hosp

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.

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.