

FILED APR 15 1941

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

12179
Do not use this space.

1. PLACE OF DEATH
(a) County Saline Registration District No. 79648
(b) Township Marshall Primary Registration District No. 13038 Registered No. 65
(c) City Marshall (d) Street No. Mo State Sch. 29 St.
(e) Length of residence in city or town where death occurred 17 yrs. 6 mos. 13 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Charles Bryant Thornton
(a) Residence, No. Roma City Mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MD 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 30 1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
37 3 25

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. se
9. Industry or business in which work was done, as saw mill, bank, etc. se
10. Date deceased last worked at this occupation (month and year) se
11. Total time (years) spent in this occupation se

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marshall Mo

FATHER
13. NAME Bloomfield Thornton

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

MOTHER
15. MAIDEN NAME Mary Katherine Moody

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

17. INFORMANT (ADDRESS) Files

18. BURIAL, CREMATION, OR REMOVAL PLACE Ridge Park Cem DATE 3/28 41

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Herschberger
Marshall Mo

20. FILED 3-28-41 Mary Kent Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 26, 1941

22. I HEREBY CERTIFY That I attended deceased from Jan 1 1939, to March 26 1941
I last saw him alive on March 26, 1941. Death is said to have occurred on the date stated above, at 4 a. m.

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

Intestinal
Tuberculosis

Other contributory causes of importance: 5

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

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 C. J. Mc (Signed) M. D.

(Address) Marshall Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X14023

RECEIVED
District Health Officer No. 8,
District File Number
4-11-41
Date Filed

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 Fred Wellman

Licensed Embalmer No. 2478

P. O. Address Clinton 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, above space should be left blank.