

No. 2
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X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10856

FILED APR 12 1944
Registration District No. 1944

Primary Registration District No. 4171

State File No.

Registrar's No. 193

1. PLACE OF DEATH:

(a) County. DeKalb

(b) City or town. CLARKSDALE
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: HOME - CLARKSDALE, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 87 yrs. (Specify whether years, months or days)

In this community. 87 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State. MISSOURI (b) County. DeKalb 32

(c) City or town. CLARKSDALE
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country. 1

3. (a) PRINT FULL NAME William Rachel Thornton

3. (b) If veteran, name war. -

3. (c) Social Security No. -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month. MARCH day. 16th
year. 1944 hour. 2 minute. 40 P.M.

21. I hereby certify that I attended the deceased from 3-7-1944 to 3-16-1944
that I last saw h. ER alive on 3-16-1944
and that death occurred on the date and hour stated above.

4. Sex. Female 5. Color or race. White 6. (a) Single, widowed, married. 2 divorced. Widow

6. (b) Name of husband or wife. James R. Thornton 6. (c) Age of husband or wife if alive. - years

7. Birth date of deceased. Feb. 1 - 1857
(Month) (Day) (Year)

Immediate cause of death. Pulmonary Edema - 18 hrs.

8. AGE: Years 87 Months 1 Days 16 If less than one day hr. min.

Due to. Senility

Due to. Shock from fall.

9. Birthplace. DeKalb, Buchanan Co, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation. House wife

Other conditions. (Include pregnancy within 3 months of death) NONE

11. Industry or business. -

MOTHER FATHER { 12. Name. William Green Kernes

13. Birthplace. Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name. Harrietta Vaughn

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

Major findings: Of operations. -

Of autopsy. -

PHYSICIAN -
Underline the cause to which death should be charged statistically.

16. (a) Informant. Mrs. Rebecca Thornton

(b) Address. Clarkdale Mo.

17. (a) Burial (b) Date thereof. 3-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Clarkdale

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify). 0320

(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?

18. (a) Signature of funeral director. Wm. W. Brown

(b) Address. Mayfield Mo.

19. (a) 3-29-44 (b) W. D. Ogley
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place)

(e) Means of injury. 1

23. Signature. J. Frank Linder (M.D. or other) 1
Address. Clarkdale Mo. Date signed. 3-16-44

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

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.....

John G. Brown

Licensed Embalmer No. 3933

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 99

Primary Registration District No. 4171

1. PLACE OF DEATH:

(a) County DeKalb
(b) City or town Clarksdale
(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 Wm Rachel Thornton

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. (Month) 15 (Day) 1906 (Year)

8. AGE: Years 87 Months 1 Days _____ If less than one day, _____ min.

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

10. Usual occupation _____ (City, town, or county) _____ (State or foreign country)

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) _____ (Date received local registrar) (b) _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 1944 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema Duration _____

Due to senility

Due to Shock from fall 610 Days

Other conditions (Include pregnancy within 3 months of death) 46a

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following: Patient blew over by wind - injuring shoulders

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 3-7-44

(c) Where did injury occur? Clarksdale DeKalb Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ON STREET IN TOWN

While at work? No. (e) Means of injury Strong wind

23. Signature D.R. Van de Linder (M. D. or other) MD

Address Clarksdale, Mo. Date signed 4-1-44

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

SUPPLEMENTARY

10856