DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 15 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5099

Registration District No. 94 Primary Registration District No. 4171 Registrar's No. 8

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 life years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County DeKalb 32
(c) City or town Clarksdale 8
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Solomen J. Thornton
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex Male 5. Color or race W 6. (a) Single, ~~widowed~~, married, ~~divorced~~ 0

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

7. Birth date of deceased June (Month) 26 (Day) 1879 ~~46~~ (Year)

8. AGE: Years 66 Months 6 Days 4 If less than one day ..... hr. ..... min.

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

10. Usual occupation Laborer

11. Industry or business .....

MOTHER
12. Name Sherman Thornton
13. Birthplace Clarksdale (City, town, or county) Mo (State or foreign country)

FATHER
14. Maiden name Rachel Kerns
15. Birthplace Clarksdale (City, town, or county) Mo (State or foreign country)

16. (a) Informant Lewis Thornton
(b) Address Clarksdale

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-30-46 (Month) (Day) (Year)
(c) Place: burial or cremation Thornton Cemetery

18. (a) Signature of funeral director John Bram
(b) Address Maysville Mo

19. (a) Feb 7 46 (Date received local registrar) (b) Roscoe Davidson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27 ~~46~~
year 1946 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ~~Dec~~ Jan 1 1946, to Jan 27 1946
that I last saw her alive on Jan 25 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia Flu	
Due to: Due to freezing	1 Mth
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 32
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0
While at work? ..... (Specify type of place) (e) Means of injury .....

23. Signature E M Reynolds (M. D. or other)
Address Elwood Kans Date signed 2-11-46

62 (Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFI
Cameron, Mo.

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 comp the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mar

Registration District No. 99 Primary Registration District No. 471 Registrar's No. 8

1. PLACE OF DEATH:

(a) County DeKalb

(b) City or town Dawsondale
(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)

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

3. (a) PRINT FULL NAME Solomon J. Thornton

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 S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased June 26 (Month) (Day) (Year)

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month day year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19..., to 19...; that I last saw h... alive on 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations 190-6
Of autopsy 40

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: Accident V
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence frozen feet 1946
(c) Where did injury occur? Fayetteville (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature E M Reynolds (M. D. or other)
Address Union Star Mo Date signed

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