

FILED MAR 15 1946

Registration District No. 99

Primary Registration District No. 4171

1. PLACE OF DEATH:

(a) County De Kalb  
 (b) City or town Clarksdale ms  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: home  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community five years, months or days

3. (a) PRINT FULL NAME THOMAS F. THORNTON  
 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, widow  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: July 4 1859  
 (Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace De Kalb Co MS  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Thornton  
 13. Birthplace Callaway MS  
 (City, town, or county) (State or foreign country)  
 14. Maiden name William Mann  
 15. Birthplace Dentry Co MS  
 (City, town, or county) (State or foreign country)

16. (a) Informant Eliza T. Thornton  
 (b) Address Clarksdale ms

17. (a) Burial (b) Date thereof 1-3-46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Clarksdale ms

18. (a) Signature of funeral director: John S. Bran  
 (b) Address Mayville MS

19. (a) Jan 5-46 (b) W. W. Davidson  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MS (b) County De Kalb  
 (c) City or town Clarksdale  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rural (If rural, give location)  
 (e) Citizen of foreign country? NO. (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1  
 year 1946 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug. 1944 to Jan 1 1946  
 that I last saw him alive on Dec 31 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Senility  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 162b  
 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? \_\_\_\_\_

(Specify type of place) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. Harold Fowler (M.D. or other) MS  
 Address Mayville MS Date signed 1-2-46

DISTRICT HEALTH OFFICE  
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: *John G. Brown*

Licensed Embalmer No. 3933

P. O. Address: *Waycross*

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

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