

FILED APR 29 1949

Registration District No. **128**Primary Registration District No. **2000**Registrar's No. **246-A**

## 1. PLACE OF DEATH:

(a) County **GREENE** **39**  
 (b) City or town **Springfield**  
 (c) Name of hospital or institution: **St. John's Hospital** **6**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **0** (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME **Marilyn Jane Thornton**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **No.**  
 4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, (married), divorced **Infant**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive **Infant** years  
 7. Birth date of deceased **MARCH 6 49**  
 (Month) (Day) (Year)

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

9. Birthplace **Springfield** **Missouri**  
(City, town, or county) (State or foreign country)10. Usual occupation **Infant**

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

12. Name **Lester Igal Thornton**13. Birthplace **Protem** **Missouri**  
(City, town, or county) (State or foreign country)14. Maiden name **Carolyn Jean Gray**15. Birthplace **Nevada** **Missouri**  
(City, town, or county) (State or foreign country)16. (a) Informant **Mr. Thornton**(b) Address **FLY LAND**17. (a) **Burial** (b) Date thereof **3-12-49**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Marshallfield, Mo.**18. (a) Signature of funeral director **Jerry Dancy**(b) Address **Marshallfield, Missouri**19. (a) **3/17/49** (b) **W. H. Alley MD**  
(Date received by registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Wolfe** **112**  
 (c) City or town **Beckland** **0**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) **1**  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **13**  
 year **1949** hour **11** minute **10 a.** M.

21. I hereby certify that I attended the deceased from **March 6** 19**49** to **March 13** 19**49**  
 that I last saw her alive on **March 13** 19**49**  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
**Anencephaly, Congenital**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations **153**

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature **J. H. Jones** (M. D. or other) **MD**Address **Springfield, Mo.** Date signed **3/13/49**

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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 the above constitutes grounds for revocation of license.)**

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