

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 21 1949

State File No. 28970

BIRTH NO. \_\_\_\_\_ REG. DIST: NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 159

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Marshall, Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Marshall</b>	
c. LENGTH OF STAY (in this place) <b>One Week</b>		d. STREET ADDRESS (If rural, give location) <b>553 West Washington St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Fitzgibbons Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Luther</b>	b. (Middle) <b>Lewis</b>	c. (Last) <b>Thornton</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>August 9-1949</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 29-1890</b>	9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR Months <b>10</b>	IF UNDER 24 Hrs. Hours <b>0</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Worked at Shoe Factory-Lasting Dept.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Saline City, Missouri</b>	11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Issac L. Thornton</b>	13b. MOTHER'S MAIDEN NAME <b>Quilla Johnson</b>	14. NAME OF HUSBAND OR WIFE <b>Kitty Neff Thornton</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>497-14-9145</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Charles Eddy-Marshall, Mo.</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <b>P.O. Pulmonary Embolism</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Chr. Choleseptitis</b>		
DUE TO (b)			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>585X</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Chr. Choleseptitis &amp; Leonticosis</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 9, 1949, to Aug 9, 1949, that I last saw the deceased alive on Aug 7, 1949 and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Robert Kennedy M.D.</b>	23b. ADDRESS <b>Marshall Mo.</b>	23c. DATE SIGNED <b>8-9-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Aug. 12-1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Ridge Park</b>	24d. LOCATION (City, town, or county) (State) <b>Marshall, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>Aug. 10-1949</b>	REGISTRAR'S SIGNATURE <b>Sidney J Gray</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. Leslie Anderson</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4072

State File Number  
Date Filed 8-19-49

VS  
MAY 19 1957

SEP 6  
1957

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed J. Leslie Surrency

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3235

P. O. Address Marshall, W. Va.

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, fact should be so stated above.