

25345

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6907

FILED AUG 2 - 1954

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pike	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Louisiana	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Barnes Hospital		e. STREET ADDRESS (If rural, give location) 0821/	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) ABBIE	b. (Middle)	c. (Last) THORNTON	7-25-54	(Month)	(Day)

5. SEX female 2	6. COLOR OR RACE colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 4-25-1909	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	Hours	Mins.
-----------------	--------------------------	--	----------------------------	------------------------------------	------------------------	----------------------	-------	-------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Louisiana, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	----------------------------------

13a. FATHER'S NAME Robert Bates	13b. MOTHER'S MAIDEN NAME Mary Whitaker	14. NAME OF HUSBAND OR WIFE Lafayette Thornton
---------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lafayette Thornton, St. Louis, Mo.
---	------------------------------	--

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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	DUE TO (b) Pulmonary Oedema		
ANTECEDENT CAUSES	DUE TO (c) Cardiac Hypertrophy		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--

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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4343
---	--	---------------------------------

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at 8:18 P. M., from the causes and on the date stated above.

23a. SIGNATURE Patrick E. Taylor Esquire	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 7-26-54
--	-------------------------	--------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-26-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Louisiana, Mo.
---	-------------------	------------------------------------	--

DATE REC'D BY LOCAL REG. AUG 26 1954	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. B. Sterne, Louisiana, Mo.
--------------------------------------	----------------------------------	---

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

No. 300
10-48

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..

Student.....
Signature of Student Embalmer

Signed *Ronald W. Zahn*.....

Licensed Embalmer No. *391*

P. O. Address *St. Louis*

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**