

Health, Welfare, Public Service, 300, 1-56, 0970, 292, diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All deaths (except venereal) returned to the coroner when (a) the symptoms will be listed. All

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016997

STATE FILE NUMBER

FILED APR 9 1958

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 21

|   |  |   |  |  |  |   |   |  |
|---|--|---|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Saline</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>                                 |  |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Slater</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>      |  | c. CITY OR TOWN <u>Slater</u>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>none</u>  |  | Length of stay in lb<br><u>50 yrs</u>   |  | d. STREET ADDRESS (If outside, give location)<br><u>Jefferson</u>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lorena</u> Middle <u>/</u> Last <u>Thornhill</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>25</u> Year <u>1958</u>  |  |   |   |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>negro</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> <u>3</u> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Nov. 22-1887</u>   |   |  |
| 9. AGE (In years last birthday)<br><u>70</u>  |  | IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>3</u>  |  | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>   |  |   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>house-work</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and state or country)<br><u>Saline County, Mo.</u>               |   |  |
| 13. FATHER'S NAME<br><u>Robert Wilson</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U S</u>   |  |   |   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Fanny Richardson</u>   |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u> <u>no</u>                                     |  |   |   |  |
| 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Allie Houston</u>   |  |  |  | Address<br><u>Slater, Mo.</u>   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Primary Insufficiency</u><br>DUE TO (b) <u>Generalized Arteriosclerosis</u><br>DUE TO (c) <u>4201</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3-6 days</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) |  |  |   |   |  |
| 20c. TIME OF INJURY<br>Hour <u></u> Month, Day, Year <u></u><br>a. m. <u></u> p. m. <u></u>   |  |   |  |  |  |   |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |  | 20f. CITY, TOWN, OR LOCATION   |  | COUNTY STATE  |   |  |
| 21. I attended the deceased from <u>March 1956</u> to <u>March 1958</u> and last saw her <u>alive</u> on <u>March 24-58</u><br>Death occurred at <u>3 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.   |  |   |  |  |  |   |   |  |
| 22a. SIGNATURE<br><u>S. Niles</u> (Degree or title) <u>0</u>  |  |   |  | 22b. ADDRESS<br><u>313 N. Main Slater Mo</u>   |  | 22c. DATE SIGNED<br><u>3-26-58</u>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>3/28/1958</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Moriah</u>  |  | 23d. LOCATION (City, town, or county) (State)<br><u>Slater, Mo</u>                    |   |  |
| 24. FUNERAL DIRECTOR<br><u>Hill Brothers, Slater Mo</u>   |  |   | ADDRESS  |  | 25. DATE RECD. BY LOCAL REG.<br><u>3-29-58</u> |   | 26. REGISTRAR'S SIGNATURE<br><u>Mrs. Earl C. Metz</u>   |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION Completed by affidavit 4/25/58

(Licensed Embolmer's Statement on Reverse Side)

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 *Sam M. Hill*

Licensed Embalmer No. *12*

P. O. Address *Slater*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.