

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

30573

**1. PLACE OF DEATH**

County Greene Registration District No. 318  
 Township \_\_\_\_\_ Primary Registration District No. 2001  
 City Springfield (No. 917 E. Scott) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 671  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

James Henry Thornhill  
 (a) Residence No. 917-E-Scott St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Irene Thornhill

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1 - 1897

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>32</u>	<u>23</u>	<u>14</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Labourer  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) East St. Louis  
 (STATE OR COUNTRY) Illinois

10. NAME OF FATHER James Thornhill

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Lettie Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sparta  
 (STATE OR COUNTRY) Illinois

14. INFORMANT Mrs Irene Thornhill  
 (Address) 917-E-Scott

15. FILED 9-17-29 Luc Sharp REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep 15 1929

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_, that I last saw him alive on Sep 6 1929, and that death occurred, on the date stated above, at 6:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Bullet wound of lung  
173 Homicidal  
1092 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Hemorrhage  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED? \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? Yes  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) Anna C. Stone, M.D.  
Sep 18, 1929 (Address) Springfield, Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lincoln Memorial DATE OF BURIAL Sept 18 1929

20. UNDERTAKER H. H. Smith ADDRESS 603-N. 9th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

39  
5-6-29

297  
2

681

119