

OCT 17 1935

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

Do not use this space.

28587

1. PLACE OF DEATH

County Adair
Township Morrow
City (Name) _____

Registration District No. 1039
Primary Registration District No. 1010

File No. 10
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Stephen S. Thorington

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

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

2. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah J. Thorington

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 28 - 1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
54 11 26

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER George R. Thorington

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Mary Friend

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

14. INFORMANT (Address) Sarah J. Thorington
Stahl, Mo.

15. FILED Sept 25 1935 Mrs Gale Morelock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 23 1935

17. I HEREBY CERTIFY That I attended deceased from June 1, 1935 to Sept 23, 1935 that I last saw h. a. m. alive on Sept 6, 1935 and that death occurred, on the date stated above, on Sept 3 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Liver

CONTRIBUTORY (SECONDARY) WHO (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? no

(Signed) H. J. Garrison, M. D. (Address) Springer 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 McGrew Cemetery DATE OF BURIAL Sept. 24 1935

20. UNDERTAKER Llewellyn & Son ADDRESS Novinger Mo

M. 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.

