

JUN 2 - 1939

REC'D JUN 8 1939

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

19734  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784  
(b) Township Kirkwood Primary Registration District No. 106  
(c) City Kirkwood (d) Street No. St. Agnes Home St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John W. Thornhill

(a) Residence, No. St. Agnes Home St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Abt. 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
Abt. 70 Unknown

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

FATHER 13. NAME Adison Thornhill

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Virginia

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Margaret Thornhill  
St. Agnes Home

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE 6/3/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. C. Moydell  
1926 Allen, Ave.

20. FILED JUN 2 - 1939 DR. Meyers Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/1/39, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 25, 1939, to June 1, 1939  
I last saw h/m. alive on June 1, 1939. Death is said to have occurred on the date stated above, at 7-15<sup>PM</sup> m.  
The principal cause of death and related causes of importance were as follows:

Acute Cordial Debilitation  
Date of onset 6/1/39

Other contributory causes of importance:  
Cordis to sceler  
Renal Disease  
Conditent Abilitous  
Swelling feet  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) W. C. Moydell, M. D.  
DR. Meyers (Address) 1926 Allen, Ave.

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.

**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 .....

Registered Apprentice No. ...., working under my personal supervision.

Signed.....

*Benj. C. Duncan*

Licensed Embalmer No. *2272*

P. O. Address *1926 Allen*

**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, above space should be left blank.**