

Registration District No. 4

Primary Registration District No. 3001

State File No. _____

Registrar's No. 137

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kingsville Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Grain-Smith Hospital 1
 (If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 3 days (Specify whether
 In this community 25 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County PUTNAM
 (c) City or town RURAL (Unionville, Mo)
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
 year 1944 hour 6 minute 33 P.M.
 21. I hereby certify that I attended the deceased from June 4,
 _____, 1944, to June 6, 1944,
 that I last saw him alive on June 6, 1944:
 and that death occurred on the date and hour stated above.

Immediate cause of death: _____ Duration
Rupture of cerebral artery into brain & rupture of spleen. 3 days
 Due to: Cerebral artery (rupture)
Atelectasis of left lung.
 Due to: _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

 3 While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature [Signature] M.D. (M. D. or other) 1
 Address Kingsville, Mo. Date signed 6-6-44

3. (a) PRINT FULL NAME Emmanuel Winford Thorne
 3. (b) If veteran, name war No. 3. (c) Social Security No. 120

4. Sex M. 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Hectorine Thorne 6. (c) Age of husband or wife if alive 32 years
 7. Birth date of deceased 25PT 18 1903 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 8 18 hr. _____ min.

9. Birthplace Adair Co Missouri (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business Farm

12. Name William Thorne

13. Birthplace Iowa (City, town, or county) (State or foreign country)

14. Maiden name Mary Fears

15. Birthplace Putnam Co Missouri (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hectorine Thorne

(b) Address Unionville, Mo.

17. (a) Burial (b) Date thereof June 8 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Unionville Mo

18. (a) Signature of funeral director [Signature]

(b) Address Unionville, Mo

19. (a) June 10/44 (Date received local registrar) (b) Power L Meeman (Registrar's signature)

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.

152

RECEIVED

District Health Officer No. 10

District File Number 6-40-1288

Date Filed JUN 13 1940

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

J. W. Comstock

Registered Apprentice No. 1325

working under my personal supervision.

Signed

J. W. Comstock

Licensed Embalmer No. 3891

P. O. Address

Unionville, Mo.

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.

Registration District No. 4

Primary Registration District No. 3001

Registrar's No. _____

1. PLACE OF DEATH

(a) County Adair
(b) City or town Garrettsville mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Emmanuel Winifred Thomas

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 36 Months 6 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

CERTIFICATION

20. DATE OF DEATH: Month June day 6 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of ear -
Medical abscess into
larynx + aspiration of
neck; atelactasis of left
lung.
Due to _____
Due to _____
Other conditions Cause unknown
(Include pregnancy within 3 months of death) (M)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature J. H. Kemp (M. D. or other) _____

Address Garrettsville mo Date signed _____

SUPPLEMENTAL

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

S-17725