

FILED FEB 18 1941

State File No. 1786

Registration District No. 799

Primary Registration District No. 6043

Registrar's No. One

1. PLACE OF DEATH:

(a) County Saline Co.
(b) City or town Slater MO, R. No. 2. 10
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 80 years
In this community 80 years
years, months or days

8. (a) PRINT FULL NAME I. P. Thornton

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

4. Sex Male 6. Color or race white 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased June 17, 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 4 If less than one day hr. _____ min.

9. Birthplace Near Saline City Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Flem Thornton

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

14. Maiden name Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Flem Thornton

(b) Address Slater Mo.

17. (a) Burial (b) Date thereof Jan. 23, 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concord Near Slater Mo

18. (a) Signature of funeral director Jones and Salzer

(b) Address Slater Mo.

19. (a) Jan 23 (b) W. M. Tuttle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan, day 21
year 1941 hour 11 minute 30 P. M.

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

Immediate cause of death Pneumonia

Due to Influenza

Due to Chr. Nephritis

Other conditions Chr. Nephritis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

23. Signature G. A. M. Money D. O. _____
Address Slater Mo Date signed _____

Duration

1, 1/2

10 days

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

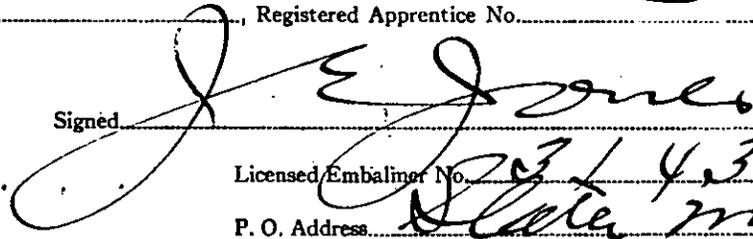
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RECEIVED
District Health Officer No. 8,
District File Number 2-13-41
Date Filed

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  _____
Licensed Embalmer No. 203143
P. O. Address State 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.

Isaac P

MISSOURI STATE BOARD OF HEALTH
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 4473

Registration District No. 799

Primary Registration District No. 6043

Registrar's No.

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

1. PLACE OF DEATH

(a) County Saline

(b) City or town Clay, T. P.
(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 _____ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Isaac P Tharnton

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 Wed

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 73 Months 7 Days 4 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-22 (Date received local registrar) (b) W. M. Tuttle (Registrar's signature)

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

20. DATE OF DEATH Month 1 day 21 year _____ 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 _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 P. G. McBurney (M. D. or other) _____

Address States mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL CERTIFICATE

