

FILED OCT 1 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31269

Registration District No. 125

Primary Registration District No. 3009

Registrar's No. 2

1. PLACE OF DEATH:

(a) County: Cape Girardeau  
(b) City or town: Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether  
In this community  
years, months or days)

3. (a) PRINT FULL NAME: James Thornton

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

4. Sex: MA 5. Color or race: C  
6. (a) Single, widowed, married, divorced: Married  
6. (b) Name of husband or wife: Neace Mae Thornton  
6. (c) Age of husband or wife if alive: 28 years  
7. Birth date of deceased: Dec. 28 1912  
(Month) (Day) (Year)

8. AGE: Years: 28 Months: 8 Days: 4  
If less than one day  
hr. min.

9. Birthplace: Hollygrove Ark. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business:

MOTHER FATHER { 12. Name: Brown Thornton  
13. Birthplace: 9  
(City, town, or county) (State or foreign country)  
14. Maiden name: Zella Baldwin  
15. Birthplace: Marvonn Ark. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant: Neace Mae Thornton  
(b) Address: Matthews, Mo. #3  
17. (a) Burial (b) Date thereof: 9-4-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation: Sikeston, Mo.

18. (a) Signature of funeral director: Albritton F.H.  
(b) Address: Sikeston, Missouri  
(c) 9-15-41 (b) F.H. Phillips  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: New Madrid 72  
(c) City or town: Canalou Rural  
(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 9 day 1  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 9-1  
1941 to 9-1 1941  
that I last saw him alive on 9-1  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Edema  
Due to: Undetermined

Due to: 111c  
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?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury: \_\_\_\_\_  
23. Signature: A. B. Elrod (M. D. or other) 0  
Address: Cape Girardeau Mo. Date signed: \_\_\_\_\_

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

---

**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.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c  
the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**