

S. No. 2
OM-2-43
5-17-39
I X38697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30461**
Registrar's No. **8029**

FILED SEP 17 1943
Registration District No. **213**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3524 a McKean Ave.
(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

3. (a) PRINT FULL NAME Fannie Tate Thornhill
3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow
6. (b) Name of husband XXX 6. (c) Age of husband or wife if alive Dec. years
B.W. Thornhill
7. Birth date of deceased Dec. 20 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>8</u>	<u>17</u>	hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name James C. Coghill
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Minerva MacLeary
15. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant Bert R. Thornhill
(b) Address 3524 a McKean Ave

17. (a) Burial (b) Date thereof 9-9-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem

18. (a) Signature of funeral director Wm J. Robert & V. Co.
(b) Address 1925 S. Gay St. St. Louis Mo

19. (a) SEP 9 1943 (b) J.F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3524 a McKean Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7
year 1943 hour 1 minute 50 AM.

21. I hereby certify that I attended the deceased from July 16
1943 to Sept 17 1943
(that I last saw him alive on Sept 17 1943
and that death occurred on the date and hour stated above.)

Immediate cause of death Left hemiplegia
hypoglycemia
arteriosclerosis

Due to Smile
Due to _____

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

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 Wm J. Robert (M. D. or other) WJ
Address 1705 S. Grand Date signed 9-8-43

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.....

John Fetter
.....
Licensed Embalmer No. *3880*
.....

P. O. Address.....

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, fact should be so stated above.