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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED DEC 17 1943

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 292

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
116 W. Kansas
(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 Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 121 E. Kansas
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

Edmund E. Thornburg
3. (b) If veteran, name war None
3. (c) Social Security No. 494-20-7814

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Edna Thornburg
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased Nov. 20 1884
(Month) (Day) (Year)

8. AGE: Years 59 Months 0 Days 0
If less than one day
.....hr.min.

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

10. Usual occupation Inspector, Instrument Man

11. Industry or business State Highway Dept.

MOTHER FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Edna Thornburg
(b) Address Butler, Mo.

17. (a) Removal (burial, cremation, or removal) (b) Date thereof Nov. 23-43
(Month) (Day) (Year)
(c) Place: burial or cremation Butler, Mo.

18. (a) Signature of funeral director Geo. C. Carson
(b) Address Independence, Mo.

19. (a) 11-22-43 (Date received local registrar) (b) Jameson Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
year 1943 hour 10 minute 15A. M.
21. I hereby certify that I attended the deceased from Nov. 1
..... 1943, to Nov. 20..... 1943;
that I last saw him alive on Nov. 29..... 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute cardiac dilatation
Due to Chronic alcoholism Duration 15 mo.

Due to.....
Other conditions (Include pregnancy within 3 months of death) 95 C4

PHYSICIAN
Major findings: Of operations.....
Of autopsy.....
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 2
23. Signature Virgil L. Hawkins (M. D. or other) MD
Address Carl Bldg. Indep. Mo. Date signed 11-20-43

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

1163

(Licensed Embalmer's Statement on Reverse Side)

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 *George C. Carson*

Licensed Embalmer No. *2249*

P. O. Address *Independence, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____ JAN

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 292

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Independence
(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 years, months or days)
 In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Edmund E. Thornburg

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. Nov 20 1920
(Month) (Day) (Year)

8. AGE: Years 59 Months _____ Days _____ If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) James W. Ross
(Date received local registrar's certificate) (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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 20 Year 1943 hour _____ minute _____ M.

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

Duration

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-42577