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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 15 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1478

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 8 days
In this community _____ (Specify whether years, months or days) unknown

3. (a) PRINT FULL NAME James Thornton

3. (b) If veteran, name war. NO 3. (c) Social Security No. none

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Divorced

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

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

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business _____

12. Name Chas Thornton

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

14. Maiden name Dorothy New

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

16. (a) Informant Grand Child

(b) Address General Wash

17. (a) Removal (b) Date thereof 4/13/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Denver Colo

18. (a) Signature of funeral director Spaw murray
(b) Address 2315 Lawrence

19. (a) 4-3-44 (b) J. L. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 616 No. Park
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1944 hour 1 minute 20 A. M.

21. I hereby certify that I attended the deceased from March 23, 1944 to April 1, 1944
that I last saw him alive on April 1, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Cardiac decompensation

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 A. E. Washer Med. Dir. M.D.
(M. D., Mother)

Address 23 M. Coy Date signed _____

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

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 comply with the above constitutes grounds for revocation of license.)

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