

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 9 1944

Registration District No. 1518

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital
(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 St. Louis
(c) City or town Maplewood
(If outside city or town limits, write "RURAL")
(d) Street No. 2286 Yale
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wilcox G. Thorne

3. (b) If veteran, name war World War # 1 3. (c) Social Security No. Unknown

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

6. (b) Name of husband or wife Ruth Thorne 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Sept. 24 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 7 1 hr. _____ min

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

10. Usual occupation Physician and Surgeon

11. Industry or business _____

12. Name George Thorne

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

14. Maiden name Adeline Wilcox

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

16. (a) Informant Ruth Thorne
(b) Address Washington, D. C.

17. (a) Cremation (b) Date thereof 4-28-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) APR 29 1944 (b) J. Beck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 25
year _____ hour 9 minutes 10 a.m.

21. I hereby certify that I attended the deceased from June 16, 1942
_____ 19 _____ to April 25 19 44
that I last saw him alive on April 18 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Cachexia due to general cancer
Due to cancer of Larynx Duration About 2 years

Due to _____
Other conditions Hypertension

Major findings: Of operations Cancer of Larynx
Of autopsy no

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 [Signature] (M. D. or other) _____
Address 2074 WALL BLDG Date signed 4/29/44

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

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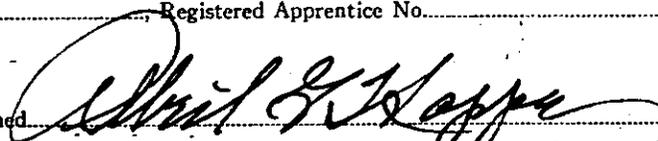
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MOTHER FATHER

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..... 2971

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.