

UNITED STATES DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

# 9 12222  
State File No. \_\_\_\_\_  
Registrar's No. 371

FILED MAY 12 1948

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: O'Reilly VA Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 Months  
In this community 10 Months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Sebastian  
(c) City or town Fort Smith  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1605 North Lyman Street  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Tomie Thornton

3. (b) If veteran, name war WW I 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Margett Thornton 6. (c) Age of husband or wife if alive 35 years  
7. Birth date of deceased April 6, 1891  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
55 9 26 10 hr. 32 min.

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

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 VA CORRESPONDENCE RECORDS  
(b) Address Springfield, MO  
17. (a) Burial (b) Date thereof 5-3-48  
(c) Place: burial or cremation Fort Smith Ark

18. (a) Signature of funeral director Wm. J. Handley  
(b) Address Springfield, Mo.  
19. (a) 5-3-48 (Date received local registrar) (b) W. J. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2  
year 1948 hour 10 minute 32 A.M.

21. I hereby certify that I attended the deceased from June 3, 1947, to May 2, 1948  
that I last saw him alive on May 2, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic, far advanced active.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

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? \_\_\_\_\_

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

23. Signature P. L. EISELE (M. D. XXXX)  
Address VAH, Springfield, Mo. Date signed 5-3-48

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

39  
2  
6

JUN 2 1948

JUN 29 1948

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 Lewis G. Schaff  
Licensed Embalmer No. 3802  
P. O. Address Springfield, 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.