

FILED FEB 21 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43993**  
Registrar's No. **3037**

BIRTH NO. _____		REG. DIST. NO. <b>109</b>		PRIMARY REG. DIST. NO. <b>5424</b>		Registrar's No. <b>3037</b>			
1. PLACE OF DEATH a. COUNTY <b>Dunklin</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>MO.</b> b. COUNTY <b>Dunklin</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Campbell Mo. R.R.</b>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Campbell, Mo. Rural</b>		d. STREET ADDRESS (If rural, give location) <b>Union Top</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Home</b>				d. STREET ADDRESS <b>4 Mi. North</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Josephine</b> b. (Middle) <b>-</b> c. (Last) <b>Thornton</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov - 8 - 1949</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <b>Widowed</b>		8. DATE OF BIRTH <b>4-11-1872</b>			
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours		IF UNDER 1 MIN. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Johnson Co. Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Warren Smith</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Evans</b>		14. NAME OF HUSBAND OR WIFE <b>Monroe Thornton (Dec)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Nora E. Whitehead</b>				ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumonia.</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Stroke paralytic 1 week prior</b> DUE TO (c) <b>Chronic nephritis.</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>592X</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>Oct 20</b> , 19 <b>49</b> , to <b>Nov 8</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>Nov 8</b> , 19 <b>49</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>J. Carlstrom D.O.</b>				23b. ADDRESS <b>Malden Mo</b>		23c. DATE SIGNED <b>Mo 10/49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Nov. 10, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Christian Ceneter</b>		24d. LOCATION (City, town, or county) (State) <b>N. &amp; E of Campbell, Mo</b>			
DATE REC'D BY LOCAL REG. <b>2-6-1950</b>		REGISTRAR'S SIGNATURE <b>Mo. T. Beulah Campbell</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Drby</b>		ADDRESS <b>Rector Ark.</b>			

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

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FEB 21 1950

RECEIVED DUNKLIN COUNTY HEALTH  
DEPARTMENT .. 2-13-50 ..  
COUNTY FILE NUMBER .. 250-54 ..

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Signed Robert D. Cranford

Licensed Embalmer No. 826

P. O. Address Rector, Ark

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.