

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18628**
Registrar's No. **4681**

FILED JUN 6 1952
BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

3

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3110 Easton		d. STREET ADDRESS (If rural, give location) 1012 N. 20th.	
3. NAME OF DECEASED (Type or Print) a. (First) Jack b. (Middle) Thornton c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 5 16 52
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH March 15, 1880
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POOL ROOM ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY 3110 Easton	11. BIRTHPLACE (City and State or Foreign Country) Mississippi
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Cora Thornton 1012 N. 20th	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Bertha Gaines		ADDRESS 3113 Cass	
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, asthma, etc. It means the disease, injury, or complication which caused death.			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES			
DUE TO (b) Decrotizing Lesion			
DUE TO (c) Pneumonia			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 490 Xk	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:52 p.m., from the causes and on the date stated above.			
23. SIGNATURE (Degree or title) Catriek E Taylor Coronar		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 5 20 52
24a. BURIAL-CREMA-TION REMOVAL (Specify) Removal	24b. DATE May 21, 1952	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis, County Mo.
DATE REC'D BY LOCAL REG. MAY 20 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE J. B. L... 1221 Myrtle ADDRESS	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Clarence Craun

Licensed Embalmer No. 4755

P. O. Address 1321 N. Grand

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.