

THE DIVISION OF HEALTH OF THE STATE OF MISSISSIPPI
STANDARD CERTIFICATE OF DEATH

Shaggo 1273
State File No.

No. 300
10-48

FILED JAN 31 1953

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

BIRTH NO. _____		REG. DIST. NO. <u>142</u>		PRIMARY REG. DIST. NO. <u>5386</u>		Registrar's No. <u>13</u>	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Tennessee</u> b. COUNTY <u>Shelby</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Mountain View</u>		c. LENGTH OF STAY (In this place) <u>12 hrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Memphis</u>		<u>8410</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>244 North Garland St.</u>			
3. NAME OF DECEASED (Type or Print) <u>MYRTLE</u>		a. (First)		b. (Middle) <u>THORNTON</u>		c. (Last) <u>BRYAN</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 8-1952</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>July 11-1885</u>		9. AGE (In years last birthday) <u>67</u>		10. UNDER 1 YEAR Days <u>5</u>		11. UNDER 24 HRS. Hours <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Hope, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>L E Thornton</u>		13b. MOTHER'S MAIDEN NAME <u>Amelia Senff</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Malvern Bryan</u> <u>US Army Hospt. Ft Wood, Mo.</u>			
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) <u>Cerebral Injury</u> ANTECEDENT CAUSES Morbid conditions, (if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Automobile Accident</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Compound Fractured Left femur</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>1010</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Birch Tree</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Birch Tree Shannon Mo</u>			
21d. TIME OF INJURY <u>Jan 7-1953 5P</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile Accident</u>			
22. I hereby certify that I attended the deceased from <u>Jan 7</u> , 1953, to <u>Jan 8</u> , 1953, that I last saw the deceased alive on <u>Jan 8</u> , 1953, and that death occurred at <u>1:10 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Thomas R Shaggo M.D.</u>				23b. ADDRESS <u>Mt View Mo</u>		23c. DATE SIGNED <u>Jan 19-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Jan 9-1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Memphis, Tenn.</u>	
DATE REC'D BY LOCAL REG. <u>1-28-53</u>		REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Duncen funeral Home Mtn View, mo</u>			

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 *Joel P. Duncan*

Licensed Embalmer No. *43257*

P. O. Address *St. Louis, 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.