

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27351

State File No.

FILED AUG 6 - 1953

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 2036

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Wellston</u>		c. LENGTH OF STAY (In this place) <u>18 yrs. 9 mos.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis Kelda Village</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Vincent's Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>7301 St. Charles Rock Rd.</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>Margaret</u> b. (Middle) <u>(Sr. St. Leona)</u> c. (Last) <u>Thornton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 26 1953</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>11-3-1900</u>		9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months <u>8</u> Days _____	IF UNDER 48 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>	11. BIRTHPLACE (City and State or Foreign Country) / <u>Buckingham, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
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13a. FATHER'S NAME <u>Thomas Thornton</u>		13b. MOTHER'S MAIDEN NAME <u>Hannah G. Harty</u>		14. NAME OF HUSBAND OR WIFE <u>Name</u>	
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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. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mother Superior - Mt. Carmel Dubuque, Iowa</u>			
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Subdural hemorrhage rt. cerebral hemisphere</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Generalized Arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Year days</u> <u>Year</u>	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331X</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
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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)	
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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?			
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22. I hereby certify that I attended the deceased from 10-17-, 1953, to 7-26-, 1953, that I last saw the deceased alive on 7-25-, 1953, and that death occurred at 3:20 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. A. Costello M.D.</u>		23b. ADDRESS <u>2407 N. Broadway, St. Louis</u>		23c. DATE SIGNED <u>7/26/53</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>7-26-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Dubuque Iowa</u>		
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DATE REC'D BY LOCAL REG. <u>7-26-53</u>	REGISTRAR'S SIGNATURE <u>Harriet R. Domb-M.D. P.T.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Franklin J. Donnelly 3840 Lindell St. St. Louis</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4699

P. O. Address [Signature]

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.