

Health, Welfare  
Public Service

Dr. Lowe Jr.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009619  
STATE FILE NUMBER

FILED APR 7 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 353

300  
-57  
0

1. PLACE OF DEATH. a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b> <b>0398</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		d. STREET ADDRESS <b>Route # 4 Box # 138</b>	
Length of stay in 1b <b>58 Yrs.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>JAMIE</b>	Middle <b>HAROLD</b>	Last <b>THORNHILL</b>	Month <b>March</b>	Day <b>31</b>	Year <b>1958</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22 1899</b>	9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	--	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Bill Clerk</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Frisco</b>	11. BIRTHPLACE (City and state or country) <b>Springfield, Mo. 0</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	--	---	--

13a. FATHER'S NAME <b>J.H. Thornhill</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Corlett</b>	14. NAME OF HUSBAND OR WIFE <b>Ada M. Thornhill</b>
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT Address <b>Mrs. Ada Thornhill Rt # 4 Spfld, Mo.</b>
--	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--

21. I attended the deceased from **4/1/58** to **how** and last saw <sup>him</sup> alive on **Can't remember**  
Death occurred at **6:15 p.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Arace A Lowe, M.D.</b>	22b. ADDRESS <b>430 South St.</b>	22c. DATE SIGNED <b>4/1/58</b>
---	--------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4/3/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Eastlawn</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>
--	----------------------------	---	--

24. FUNERAL DIRECTOR <b>H.H. Lohmeyer</b>	ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-1-58</b>	26. REGISTRAR'S SIGNATURE <b>John S. Melton</b>
--	------------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUN 6 1958

APR 9 1958

MS APR 9 1958

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 .....  
Signature of Student Embalmer

Signed *A. L. Mc Carr* .....

Licensed Embalmer No. *2727*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.