

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017762

FILED VS) MAY 12 1960

317

Primary Registration District No. 590

Registrar's No. 1130

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) Rural Wellston		Length of stay in 1b 2 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Vincent's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4910 N. Union Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES D. Middle THORNTON Last			4. DATE OF DEATH Month April Day 2 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-29-18	9. AGE (last birthday) 41	IF UNDER 1 YEAR Months 10 Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transformer Assembler		10b. KIND OF BUSINESS OR INDUSTRY Transformers	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Bert Thornton		13b. MOTHER'S MAIDEN NAME Sarah Brooks		14. NAME OF HUSBAND OR WIFE Mrs. Grace Thornton		
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. 489-18-9782		17. INFORMANT Mrs. Grace Thornton, wife. Address Same as patient.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 15 hours		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Skull fracture		DUE TO (c) 903.7-44		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fall upon cement floor while a patient at St. Vincent's Hospital				
20c. TIME OF INJURY 9:00 p.m. Hour 4 Month 1 Day 60 Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 35 hospital				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 35 hospital		20f. CITY, TOWN, OR LOCATION St. Louis		COUNTY Missouri		STATE
21. I attended the deceased from March 31, 1960 to April 2, 1960 and last saw him alive on April 2, 1960 Death occurred at 1:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>T. E. Roberts</i> (Type name) T. E. Roberts M.D. Coroner			22b. ADDRESS Clayton, Mo. 7301 St. Charles Rock Rd.		22c. DATE SIGNED 4/2/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 4/6/60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis Mo.		
24. FUNERAL DIRECTOR Drehmann-Harral		ADDRESS 1905 Union		25. DATE RECD. BY LOCAL REG. 4-5-60	26. REGISTRAR'S SIGNATURE <i>John B. Murphy</i>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS MAY 12 1960

MAY 13 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Albert R. Thompson

Licensed Embalmer No. 4287

P. O. Address H. J. Davis

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.