

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-045094

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 6582

6582

AMENDED

FILED JAN 15 1962

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>LINN</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in lb <b>4 YEARS</b>	c. CITY OR TOWN <b>LACLEDE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>NEUROLOGICAL HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>WASHINGTON GRISWOLD THORNE</b>			4. DATE OF DEATH Month Day Year <b>DEC. 30 1961</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>5-22-89</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MORTICIAN RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FUNERAL HOME</b>	11. BIRTHPLACE (City and state and country) <b>FOUNTAIN GROVE, MO. USA</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>JOHN W. THORNE</b>		13b. MOTHER'S MAIDEN NAME <b>EMMA GRISWOLD</b>	14. NAME OF HUSBAND OR WIFE <b>GERTRUDE T. THORNE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>MRS. GERTRUDE THORNE, LACLEDE, 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>Rupture ANEURYSM, abdominal aortic aneurysm</b>					INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>aneurysm abdominal aorta</b>					<b>months</b>
DUE TO (c) <b>Arteriosclerosis of aorta</b>					<b>YRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Brain Syndrome assoc with arteriosclerosis</b>				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 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 a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>10/11/57</u> to <u>12/30/61</u> and last saw her <sup>her</sup> alive on <u>12/30/61</u> Death occurred at <u>10:10</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>James W. Vaughn M.D.</b>			22b. ADDRESS <b>2625 W Paseo, Kansas City, MO.</b>		22c. DATE SIGNED <b>12/30/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>12-30-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LACLEDE CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>LACLEDE, MISSOURI</b>		
24. FUNERAL DIRECTOR ADDRESS <b>D. W. Newcomer's Sons Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-30-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

James W. Vaughn

JAN 16 1962

**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 Thomas W. Pearson

Licensed Embalmer No. 4889

P. O. Address Lathrop, W. Va.

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.