

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044962

11599

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11599**

FILED DEC 7 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK  
OR  
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

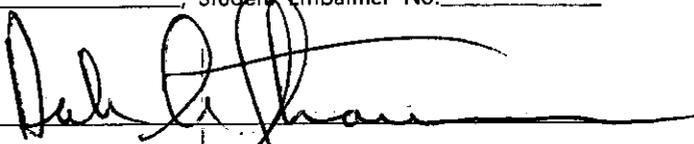
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		a. STATE <b>Mo.</b> b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Frazier Nursing Home</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4508a Clayton Ave.</b>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <b>GEORGE</b> Middle Last <b>THORNHILL</b>		Month <b>Dec.</b> Day <b>1</b> Year <b>1962</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-9-1873</b>
9. AGE (last birthday) <b>89</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Dealer (Retired)</b>	
11. BIRTHPLACE (City and state or country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown Thornhill</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Late Anna Thornhill</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>No None</b>	
16. INFORMANT <b>Mrs. Charles Frank 4508a Clayton Ave.</b>		17. ADDRESS	
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>arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 yrs. known</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>420.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Worked Generalized 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.	20d. INJURY OCCURRED WHILE AT WORK <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 <b>Oct. 19, 1962</b> to <b>Dec. 4, 1962</b> and last saw <sup>her</sup> him alive on <b>Nov. 27, 1962</b> . Death occurred at <b>4:45 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Monte A. Dill M.D.</b>		22b. ADDRESS <b>7546 Manchester Ave Maplewood 17, Mo.</b>	22c. DATE SIGNED <b>12-3-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Dec. 5, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>	
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 3- 1962</b>	
ADDRESS		REGISTRAR'S SIGNATURE <b>Roald Smith, M.D.</b>	

**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 

Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

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.