

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1707

1. PLACE OF DEATH

County Jackson
Township Stow
City St. Mo.

Registration District No.

399

Primary Registration District No.

1003

File No.

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence, No. 515 Harrison St. 2 Ward. 1
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

27 yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Stattie Horn

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

May 8, 1871

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

57

8

6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Water and Sewer

(c) Name of employer

Coal Co.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mississippi

10. NAME OF FATHER

Horn, Ned

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Alabama

12. MAIDEN NAME OF MOTHER

Campbell, Matilda

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mississippi

14.

INFORMANT

(Address)

Ab Horn
515 Harrison

15.

FILED

1-21-29 M. M. Love
REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

1-8-1929

17.

HEREBY CERTIFY That I attended deceased from 12-29-1929, to 1-8-1929, (that I last saw him alive on 1-8-1929, and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremia
131
132B
(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY)

Chronic Nephritis
unknown (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

6/17/1929 no. DATE OF
DID AN OPERATION PRECEDE DEATH? _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

H. M. Smith, M. D.
1/9, 1929 (Address) Old City Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Kirksville MO. 1/22 1929

20. UNDERTAKER

ADDRESS

West Applegate Ave 1600 E. 1929

