

Died 3/31/ -3.40 P M

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

Do not use this space.
10213
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24 1929

PLACE OF DEATH
County *Franklin*
Township
City *Washington* (No.)

Registration District No. *297*
Primary Registration District No. *2016*

File No.
Registered No. *58*
St. Ward)

2. FULL NAME *Henry William Horn*
(a) Residence No. *511 West 5th Street* St. Ward.
(Usual place of abode) (if nonresident give city or town and State)
Length of residence in city or town where death occurred *5* yrs. mos. da. How long in U.S., if of foreign birth? ~~5~~ yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Ira Holtgrewe*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 17th 1864*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
65 1 14
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Krakow Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Henry Horn*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Germany*
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER *Wilhelmine Dewert*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Germany*
(STATE OR COUNTRY)

14. INFORMANT *John Henry Tappe*
(Address) *Washington Route 3*

15. FILED *Mar 31, 1929* *O. L. Munch*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 31 1929*
17. I HEREBY CERTIFY, That I attended deceased from *Mar 17* 1929 to *Mar 31* 1929 that I last saw *h. alive* on *Mar 21* 1929, and that death occurred, on the date stated above, at *4:00* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Pectoris
944 H.P.
109 F.H.
(duration) *2* yrs. mos. da.
CONTRIBUTORY *Pneumonia 2 weeks before*
(SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *At home*
IF NOT AT PLACE OF DEATH:

0 DID AN OPERATION PRECEDE DEATH. *no* DATE OF *X*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical*
(Signed) *O. L. Munch*, M. D.

Mar. 31, 1929 (Address) *Crossway town Mo*

*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 *Ev. St. John Cemetery (Mantels) Krakow, Mo.* DATE OF BURIAL *4/3 1929.*

20. UNDERTAKER *Otto & Co.* ADDRESS *Washington, Mo.*

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

PARENTS

AGREEMENT TO STATE EXACTLY. PHYSICIAN'S SHOULD STATE. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin

Registration District No. 297

File No. 10213

Township Washington

Primary Registration District No. 2016

Registered No. 38

City Washington (No. St. Ward)

2. FULL NAME

Henry William Horn

(a) Residence. No. St. Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Feb. 31 1929 O. L. Muench REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 31 1929

17. I HEREBY CERTIFY: That I attended deceased from 19..... to 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.

..... 19 (Address)

*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

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-107-13