

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

Do not use this space.

42651

1. PLACE OF DEATH

County.....
Towaship.....
City..... (No. 1501a, S. Seventh

Registration District No. 791
1003
Primary Registration District No. 1501a S. Seventh

File No.....
Registered No. 12433
St. Ward)

2. FULL NAME Sebastian Horn

(a) Residence. No. 1501a S. Seventh St. 23 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 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 White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 30, 1846

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 7 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) II
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER II

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) II
(STATE OR COUNTRY)

PARENTS

14. INFORMANT John J. Horn
(Address) 5911 S. Kingshighway Bk

15. FILED LEC 21 1929
19. May 2 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-19 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1929, to Dec 11 1929, (that I last saw him alive on Dec 7 1929, and that death occurred, on the date stated above, at 8:30 p.m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Obstructive
Cerebral Oedema (duration) yrs. 10 mos. ds.
CONTRIBUTORY (SECONDARY)
Cerebral Oedema (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

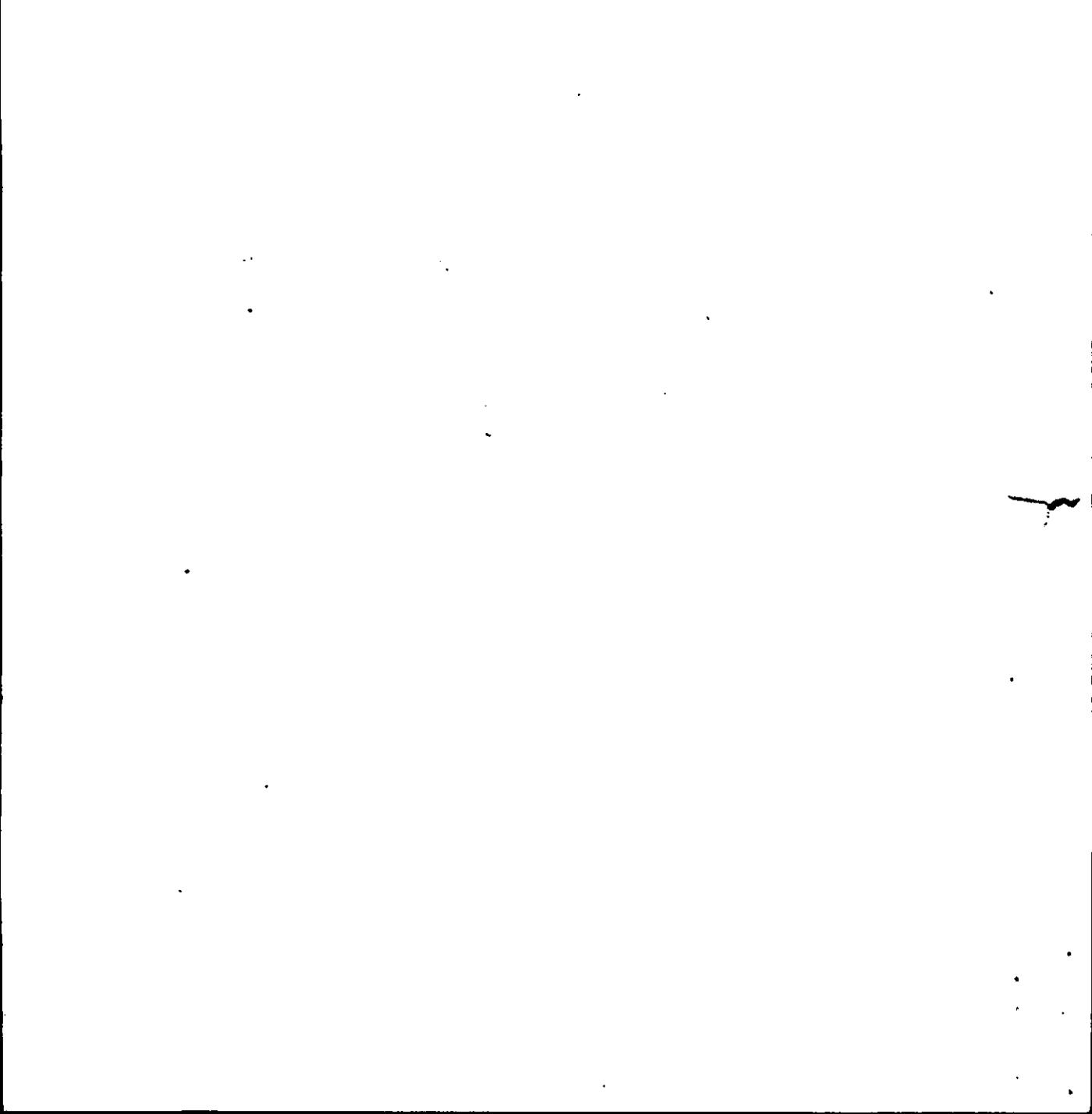
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Henry G. Pieper Ph.D., M.D.
, 19 (Address) 1736 S. Grand Blvd.

*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
New St. Marcus Cemetery Dec. 23 1929

20. UNDERTAKER ADDRESS 3732
Hauck & Schmitt S. Grand Blv.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. 12433
 City..... (No.....) St..... (Ward.....)

2. FULL NAME

Sebastian Horn

(a) Residence No..... St..... Ward.....
 (Usual place of abode) (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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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 *cigar maker*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer *Lampert Cigars Co.*

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 * *John F. Horn*
 (Address) * *5711 S. Kingshighway*

FILED *may 8 1935* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-19 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.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

5-42651