

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.

1. PLACE OF DEATH Clay
 County Clay Registration District No. 201
 Township Liberty Primary Registration District No. 5280
 City St Joseph No. _____ St. _____ Ward _____
 2. FULL NAME James Madison Farr Horn
 (a) Residence, No. Liberty, Mo., 3007 Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. 45578
 Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. ~~SINGLE, MARRIED, WIDOWED, OR~~ Widowed
~~DIVORCED (write the word)~~
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) FEBRUARY 19, 1850
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
87 9 26
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Former
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Former (Retired)
 10. Date deceased last worked at this occupation (month and year) Jan 27, 1927 11. Total time (years) spent in this occupation 50
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) PARAGON, INDIANA
 FATHER 13. NAME JAMES M. FARR,
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MORGAN CO. INDIANA
 MOTHER 15. MAIDEN NAME DELILAH TEAGUE,
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MORGAN CO. INDIANA
 17. INFORMANT Dr. G. J. Bailey
 (ADDRESS) St Joseph, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Ravenwood Mo. DATE Dec 16, 1927
 19. UNDERTAKER G. Deemer & Son Inc
 (ADDRESS) St Joseph, Mo.
 20. FILED 12/16, 1927 E. T. Branch
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) DECEMBER 15, 1927
 22. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927 to Dec 15, 1927
 I last saw him alive on Dec 14, 1927 Death is said to have occurred on the date stated above, at 11:50 aAM.
 The principal cause of death and related causes of importance were as follows:
Senility
 Date of onset _____
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) H. M. Northcutt M. D.
 (Address) St Joseph, Mo.

