

JAN 17 1939

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

44749

Do not use this space.

1. PLACE OF DEATH

(a) County Lernon 2
(b) Township
(c) City Neuada 1
(e) Length of residence in city or town where death occurred yrs. mos. ds.

Registration District No. 875
Primary Registration District No. 3039

Registered No. 316

2. PRINT FULL NAME

(a) Residence, No. 651 Joseph D. Hornback
20 Washington Street St.
(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Gerda Munn Hornback

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 11 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Medical Doctor
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Smithville, O
(STATE OR COUNTRY) Missouri

FATHER 13. NAME John Hornback

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

MOTHER 15. MAIDEN NAME Amanda Hornback

16. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

17. INFORMANT Mrs. Gertrude Hornback
(ADDRESS) Neuada Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Newton B. Park DATE Jan, 3, 1939

19. FUNERAL DIRECTOR (NAME) Harvey Funeral Dir
(ADDRESS) Neuada Mo.

20. FILED 1-2-39 1939 Allen E. Hays
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-31-1938

22. I HEREBY CERTIFY, That I attended deceased from 12/30, 1938, to 12-31, 1938
I last saw him alive on 12/20, 1938. Death is said to have occurred on the date stated above, at 1:30 a.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage
Cerebral Hemorrhage

Date of onset

Other contributory causes of importance:

Unknown

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? _____

(Signed) J. M. Galt, M. D.
(Address) Neuada Mo

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.

RECEIVED
District Health Officer No. 7
District File Number 1-13-35
Date Filed 1-17-1917

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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44749
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875
(b) Township _____ Primary Registration District No. 3039
(c) City Nevada (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Joseph T. Harnbaek
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 22 1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 11 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Jan 1 1929 Allen O'Keefe Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-31-1928

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

I last saw h. alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows: _____

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) J. M. Water, M. D.

(Address) Nevada

SUPPLEMENTARY

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

