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

NOV 20 1939

35537
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan 3 Registration District No. 85
(b) Township Primary Registration District No. 1001 Registered No. 1056
(c) or City Saint Joseph, Mo. (d) Street No. State Hospital #2, 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. 1 mos. 3 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Clarence M. Horine
(a) Residence, No. R. F. D. #3 St. [X] Norborne, Missouri
(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: 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) Mrs. Zelma Horine

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 18, 1895

7. AGE: YEARS 44 | MONTHS 4 | DAYS 28 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Not for past Yr.
11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Norborne, Carroll County, Missouri

FATHER
13. NAME Jacob Horine
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER
15. MAIDEN NAME Mary Myers
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Charlie Horine (Brother) Norborne, Missouri

18. BURIAL, CREMATION, OR REMOVAL
PLACE Norborne, Mo DATE 10/19/39 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Knipschild Hardin, Missouri

20. FILED Oct. 17, 1939 H. J. Westerbush Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from October 13, 1939, to October 16, 1939
I last saw him alive on October 16, 1939. Death is said to have occurred on the date stated above, at 2:30 P. M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Post-Operative Meningitis	10/13/39

Other contributory causes of importance:

Name of operation Ventriculogram Date of
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

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? No
If so, specify
(Signed) A. H. Panethieri, M. D.
(Address) State Hosp. No 2

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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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 Me, Registered Apprentice No. 2789, working under my personal supervision.

Signed John W. Kruipschild.

Licensed Embalmer No. 2789

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.

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1. PLACE OF DEATH
(a) County Buchanan — Registration District No. 85
(b) Township — Primary Registration District No. 1001 — Registered No. 1056
(c) City St Joseph — (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 Clarence M. Horine
(a) Residence, No. ..... 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): M
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE: YEARS 44 — MONTHS 4 — DAYS 28 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
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 Oct 17 1939 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 16, 1939
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
Post Operative Menin-	
Gitis Epilepsy	

Other contributory causes of importance:

Name of operation Ventriculogram 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) A. H. Panettiere, M. D.
(Address) State Hosp # 2

SUPPLEMENTARY

WHITE PLANET, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

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

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