

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

4
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

29244
Do not use this space.

1. PLACE OF DEATH

(a) County Madison 2 Registration District No. 621
(b) Township Clinton 0 Primary Registration District No. 5823
(c) City or Street No. _____ St. _____
(d) Street No. _____ (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

(a) Residence, No. 650 Broadway Co. no. 1 St. Rural
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Therese Horn

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 4 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 65 18

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) April 1935 11. Total time (years) spent in this occupation all

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clinton Mo

FATHER 13. NAME Alexander Jackson Horn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clinton Mo

MOTHER 15. MAIDEN NAME Olga Horn

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

17. INFORMANT (ADDRESS) Robert D Horn

18. BURIAL, CREMATION, OR REMOVAL High Mass
PLACE DATE Aug 25 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Price Undertaker
Marionville Mo

20. FILED Aug 25 1940 Robert D Horn
Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-22 1940

22. I HEREBY CERTIFY, That I attended deceased from July 27 to Aug 22, 1940
That saw him live on July 27, 1940. Death is said to have occurred on the date stated above, at 5:30 p.m.
The principal cause of death and related causes of importance were as follows:
Osteoarthritis unknown

Other contributory causes of importance: None

Name of operation None Date of _____

What test confirmed diagnosis? None Was there an autopsy? No

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) Robert D Horn M. D.

(Address) Clinton Mo

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed John W. Price.

Licensed Embalmer No. 3229.

P. O. Address Maryville Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 29244

Registration District No. 621

Primary Registration District No. 5823

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Linneston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME James Henry Haru
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 65 Months 18 Days _____ If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 22 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death: Advanced carcinoma of prostate gland not treated, not advanced to point of operable to full primary site

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. E. Ferguson (M. D. or other) _____ Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

