

Registration District No. 27

Primary Registration District No. 3079

Registrar's No. 259

RECEIVED OCT 18 1940

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

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Levering  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 week  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion  
(c) City or town Hannibal  
(If outside city or town limits write "RURAL")  
(d) Street No. 401 North Sixth  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Edward Glanvil Hornback

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased September 19, 1919  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
20 11 16 hr. \_\_\_\_\_ min.

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

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name E. R. Hornback

18. Birthplace Hannibal Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Leota Smith

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

16. (a) Informant Mrs. Leota Smith Hornback

(b) Address 401 North Sixth

17. (a) Burial (b) Date thereof 9/5/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Crawford Smith

(b) Address 902 Broadway

19. (a) 9-5-40 (b) H. Chisher  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3  
year 1940 hour 2 minute 40 P. M.

21. I hereby certify that I attended the deceased from Aug 27  
\_\_\_\_\_ 1940, to Sept 3 1940  
that I last saw him alive on Sept 3 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Meningococcus meningitis  
Polio myelitis  
Due to Lobar pneumonia  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration  
7 days -  
6 days -  
1 day

Major findings:  
Of operations Meningococcus culture  
from spinal fluid  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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?  
Y CU  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Harold Budick (M. D. or other) MD  
Address Hannibal Date signed 9-4-40

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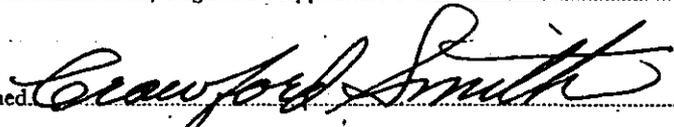
**STATEMENT BY LICENSED EMBALMER**

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



Licensed Embalmer No. .... 3814 .....

P.O. Address Hannibal Missouri .....

**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.**