

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **34260**  
**8957**  
Registrar's No. \_\_\_\_\_

Registration District No. **791**

Primary Registration District No. \_\_\_\_\_

PLACE OF DEATH:

- (a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**4001a Fairfax Avenue**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **X** (Specify whether)  
In this community **24 years** (years, months or days)

3. (a) PRINT FULL NAME **Albert Horne**

3. (b) If veteran, name war **none**  
3. (c) Social Security No. **none**

4. Sex **male**  
5. Color or race **negro**  
6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Mattie Horne**  
6. (c) Age of husband or wife if alive **51** years  
7. Birth date of deceased **12 - 10 - 1889**  
(Month) (Day) (Year)

8. AGE: Years **50** Months **10** Days **15**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Meridan Mississippi**  
(City, town, or county) (State or foreign country)

10. Usual occupation **common laborer**

11. Industry or business **unemployed**

12. Name **Sam Horne**  
13. Birthplace **unknown Alabama**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Rosie Matlick**  
(City, town, or county) (State or foreign country)  
15. Birthplace **unknown Alabama**  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mattie Horne**  
(b) Address **4001 Fairfax Ave.**

17. (a) **burial** (b) Date thereof **10-31-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **John Riley**  
(b) Address **3755 Finney Avenue**

19. (a) **OCT 30 1940** (b) **J. B. Bredenk**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")  
(d) Street No. **4001a Fairfax Avenue** (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **25** year **1940** hour **11:45** minute **A.** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculosis, Pulmonary with Cavity formation** Duration \_\_\_\_\_

Due to **Emaciation + Cachexia**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature **John Riley** (M. D. or other) \_\_\_\_\_  
Address **3755 Finney Avenue** Date signed \_\_\_\_\_

**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 L. L. D. [Signature]

Licensed Embalmer No. 2452

P. O. Address 2820 [Signature]

**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.**