. S. No. 2
I—11-10-39
v. 5-17-39
I X21492

108

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED DEC 11 1940

State File No. 40004

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 284

1. PLACE OF DEATH:

(a) County Vernon

(b) ~~City or town~~ Rural (Washington) 7

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. #3

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 years + (Specify whether

In this community 29 yrs. 5 Mos. 8 days 3 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon

(c) City or town Rural

(If outside city or town limits, write "RURAL")

(d) Street No. Washington T.P.

(If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Anna Horn

3. (b) If veteran, name war —

3. (c) Social Security No. Do not Know

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife Do not Know

6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased 2 (Month) 7 (Day) 1865 (Year)

8. AGE: Years 75 Months 7 Days 9 If less than one day ___ hr. ___ min.

9. Birthplace Do not Know (City, town, or county) (State or foreign country)

10. Usual occupation none in 29 years 9

11. Industry or business " " " " 9

FATHER
12. Name Do not Know 9
13. Birthplace Do not Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name " " "
15. Birthplace " " " (City, town, or county) (State or foreign country)

16. (a) Informant Hosp. Records

(b) Address —

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/40 (Month) (Day) (Year)

(c) Place: burial or cremation State Hosp. Cemetery

18. (a) Signature of funeral director Fern Funeral Home

(b) Address Nevada, Mo

19. (a) 11-14-40 (Date received local registrar) (b) Allen V. Hays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9th year 1940 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 1st, 1940, to Nov 9th, 1940, that I last saw her alive on Nov. 9th, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chr. Myocarditis w. degeneration	WK
Due to Chronic Asthma (Bronchial)	DK
Due to	
Other conditions (Include pregnancy within 3 months of death) 93 C	

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? 775 (Specify type of place)

While at work? (e) Means of injury

23. Signature T A Hopkins (M. D. ~~or other~~) 1

Address Nevada Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 12-40-1693
Date Filed 12-4-40

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 Lloyd R. Wunsiott
Licensed Embalmer No. 3857
P. O. Address Nevada, 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.