

Registration District No. **397**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas city  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
6932 South Benton!  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 weeks  
(Specify whether  
In this community Non-Resident  
years, months or days)

3. (a) PRINT FULL NAME Joseph Ivan Horn

3. (b) If veteran, name war no 3. (c) Social Security No 509-12-4454

4. Sex male 5. Color or race wh  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Mary K Horn  
6. (c) Age of husband or wife if alive 59 years  
7. Birth date of deceased Aug 20 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 9 5 hr. min.

9. Birthplace Shawnee / Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

MOTHER FATHER

12. Name Joseph Marion Horn  
13. Birthplace Terry Haute / Ind  
(City, town, or county) (State or foreign country)  
14. Maiden name Carandina Glover  
15. Birthplace Shawnee / Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Mary K Horn  
(b) Address 6932 S Benton Kansas city Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-26-41  
(Month) (Day) (Year)  
(c) Place: burial or cremation Shawnee Kans

18. (a) Signature of funeral director Walby N Hoge  
(b) Address Overland Park Kans  
19. (a) May 26 1941 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Leavenworth  
(c) City or town Bonner Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5 1/2 mi north west  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25  
year 1941 hour 4 minute 40 P. M.

21. I hereby certify that I attended the deceased from 5-14  
\_\_\_\_\_ 1941 to 5-25 1941  
that I last saw him alive on 5-20 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral  
hemorrhage

Due to Chronic Bright

Due to \_\_\_\_\_  
Other conditions 12/8  
(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 J. P. Mason (M. D. or other) M.D.  
Date signed 5-26-41

Duration 2  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

**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 *F. S. Watton*

Licensed Embalmer No. *2744*

P. O. Address *3030 Harrison N. E.*

**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.**