

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

JAN 13 1942 689

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH: *Pike*

(a) County *Pike*

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

(c) Name of hospital or institution: *Pike Community Hospital*
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *69*

(c) City or town *Marionville*
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) *1*

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

3. (a) PRINT FULL NAME *MARSHALL AQUILLA HORNBACK*

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex *MALE* 5. Color or race *white*

6. (a) Single, widowed, married, divorced *21*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive *85* years

7. Birth date of deceased: *Jan 21 1855*
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *12* day *2* year *41* hour _____ minute *450P* M.

21. I hereby certify that I attended the deceased from *10-22-41* to *12-2-41*, 19*41*; that I last saw him alive on *12-2-41*, 19*41*; and that death occurred on the date and hour stated above.

8. AGE: Years *86* Months *10* Days *11* If less than one day _____ hr. _____ min.

9. Birthplace: *Rails Co MO*
(City, town, or county) (State or foreign country)

Immediate cause of death: *Malignancy of the Lymphatic Nodes of the Right Axilla*

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) *5/5/41*

10. Usual occupation *Farmer*

11. Industry or business *Retired*

12. Name *Hornback*

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

14. Maiden name *(3)*

15. Birthplace (City, town, or county) (State or foreign country) *4*

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant *Miss Laura Hornback*

(b) Address *Lansiana MO*

17. (a) *Burial* (b) Date thereof *12/6/41*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Marionville Mo*

18. (a) Signature of funeral director *Nelson Funeral Home*

(b) Address *Marionville Mo*

19. (a) *12/3/41* (b) *W. H. Hales*
(Date received local registrar) (Registrar's signature)

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 a _____ (Specify type of place) _____ (d) Means of injury _____

23. Signature *W. H. Hales* (M. D. or other) _____

Address *Lansiana MO* Date signed *12/2/41*

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

12
2
1

→

→

→

RECEIVED

District Health Officer No. 10

District File Number 1-42-51

Date Filed JAN 9 1942

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.....

P. O. Address.....

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, fact should be so stated above.