

FILED MAR 27 1944  
Registration District No. 317

Primary Registration District No. 3069

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

76  
8  
3

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution:  
ST. MARY'S HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 DAY (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County ST. LOUIS <sup>100</sup>

(c) City or town ST. LOUIS <sup>17</sup>  
(If outside city or town limits, write "RURAL") <sup>9</sup>

(d) Street No. 221 N. GRAND BLVD.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME REV. SAMUEL H. HORINE S.J.

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 NOV. 13, 1878  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	65	4	4	hr. min.

9. Birthplace SPRINGFIELD MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation ROMAN CATHOLIC PRIEST

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

MOTHER, FATHER {

12. Name SAMUEL H. HORINE

13. Birthplace WATERLOO ILLINOIS  
(City, town, or county) (State or foreign country)

14. Maiden name MARY CONLON

15. Birthplace COLOMBUS OHIO  
(City, town, or county) (State or foreign country)

16. (a) Informant PAUL G. HORINE

(b) Address SPRINGFIELD MO.

17. (a) BURIAL (b) Date thereof 3-20-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FLOBISSANT MO.

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) MAR 20 1944 (b) E. S. McGarran  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 17, year 1944 hour 4 minute \_\_\_\_\_ P. A. M.

21. I hereby certify that I attended the deceased from July 14th, 1932, to March 17th, 1944, that I last saw him alive on March 17, 1944, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 day.

Due to Arteriosclerotic Vascular Disease. Hypertensive Vascular Disease Uncertain

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

Other conditions Arteriosclerotic Cardio-vascular Disease Uncertain

(Include pregnancy within 3 months of death) (Specify type of death)

PHYSICIAN \_\_\_\_\_

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

Of autopsy Confirmed diagnosis given above. <sup>93a</sup>

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 G. O. Brown (M.-D. or other) M.D.

Address 1325 S. Grand Blvd. Date signed 3/18/44

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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, Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

**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.**