

FILED JUN 29 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town K.C. MO
(c) Name of hospital or institution: Wheeler Hosp
(d) Length of stay: In hospital or institution 2 days
In this community 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State KANS (b) County WYANDOTTE
(c) City or town K C K
(d) Street No. 937 Oakland
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Lois ELIZABETH HORN

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

4. Sex FE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife HERMAN HORN 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased: JUNE 11 1913

8. AGE: 31, 0, 2 hr. min.

9. Birthplace: SPRINGFIELD, MO

10. Usual occupation: HOUSE WIFE

11. Industry or business: HOME

12. Name: CREED YOUNG

13. Birthplace: MO

14. Maiden name: MARTHA E. COKER

15. Birthplace: MO

16. (a) Informant: Lenna Mitchell

(b) Address: 1100 PASEO

17. (a) REMOVAL (b) Date thereof: 6-16-44

(c) Place: burial or cremation: SPRINGFIELD

18. (a) Signature of funeral director: [Signature]

(b) Address: K C MO
19. (a) 6-15-44 (b) T. E. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 year 1944 hour 2:30 minute p.m.

I hereby certify that I attended the deceased from June 12 1944 to June 13 1944 that I last saw her alive on June 13 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Streptococcus Tharyngitis

Due to 1158

Other conditions: (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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature: [Signature] (M. D. or other) Address: 1603 1/2 N 10th Date signed: 6/14/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

pharyngitis

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

W. G. Flynn

Licensed Embalmer No.

2211

P. O. Address:

1819 E. 15th

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.