No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 13 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34112
State File No.

Registration District No. 99 Primary Registration District No. 4171 Registrar's No. 240

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

1. PLACE OF DEATH:
(a) County De Kalb
(b) City or town Clarksdale mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution — (Specify whether years, months or days)
In this community life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County De Kalb
(c) City or town Clarksdale
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME AMBROSE L. HORSEMAN
3. (b) If veteran, name war —
3. (c) Social Security No.

4. Sex 6
5. Color or race
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 9 (Day) 1856 (Year)

8. AGE: Years	Months	Days	If less than one day
88	8	18	hr. min.

9. Birthplace De Kalb co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Robert Horseman
13. Birthplace unknown (City, town, or county) (State or foreign country)

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

16. (a) Informant Floud Horseman
(b) Address Clarksdale mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-44 (Month) (Day) (Year)
(c) Place: burial or cremation Clarksdale mo
18. (a) Signature of funeral director John Brown
(b) Address Maysville mo
19. (a) Oct 31-1944 (Date received local registrar) (b) John Clore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 28th year 1944 hour 3:00 minute A. M.

21. I hereby certify that I attended the deceased from February 18th, 1944, to Oct. 20th, 1944, that I last saw him alive on October 20th, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Edema	6 hours
Due to Chronic Myocarditis	?
Due to Senility	
Other conditions (Include pregnancy within 3 months of death)	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Dr. [illegible] (M. D. or other) DO
Address Clarksdale, Mo Date signed 10-30-44

1318

(Licensed Embalmer's Statement on Reverse Side)

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 John Braun

Licensed Embalmer No. 3933

P. O. Address Maysville 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, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

none

State File No.

Registration District No. 99 Primary Registration District No. 4171 Registrar's No. 240

1. PLACE OF DEATH:
(a) County DeKalb
(b) City or town Clarksdale
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ambrose L. Horseman
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 Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Not given years
7. Birth date of deceased Feb (Month) 9 (Day) 1856 (Year)

8. AGE: Years 88 Months 8 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (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
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Oct. 31 1944 (Date received local registrar) (b) John Clarke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. Day 28
year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

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

34112