

FILED APR 5 1945  
Registration District No. 149

Primary Registration District No. 1002

48  
3  
8

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

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: ST. LUKE'S HOSPITAL (1)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4. NO 16 DAYS  
(Specify whether years, months or days) 27 years

3. (a) FULL NAME MR. ARTHUR CHESTER HORTON  
3. (b) If veteran, name war no  
3. (c) Social Security No. 480-03-5483

4. Sex MALE  
5. Color or race WHITE  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife MRS. IRMA HORTON  
6. (c) Age of husband or wife if alive 39 years  
7. Birth date of deceased April 23 1901  
(Month) (Day) (Year)

8. AGE: Years 43 Months 10 Days 27  
If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Mountain Grove, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Chef, former Cafe

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

12. Name Frank F. HORTON

13. Birthplace unknown Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Mason

15. Birthplace unknown Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma Kella  
(b) Address 318 W. 46th St.

17. (a) burial  
(Burial, cremation, or removal) (b) Date thereof April 20 1945  
(Month) (Day) (Year)  
(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director D. H. Newcomer, Sons  
(b) Address 1401 BRUSH CREEK BLVD.  
19. (a) 3-21-45 (b) D. E. Brown  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County JACKSON  
(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL")  
(d) Street No. 318 W. 46th STREET  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 20th year 1945 hour 2 minute 30 P. M.  
21. I hereby certify that I attended the deceased from April 1944 to 3/20 1945  
that I last saw him alive on 3/20 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of liver

Due to: Carcinoma of stomach

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

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? \_\_\_\_\_  
(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)  
(c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) 0  
Address Phyg. Rev. Bldg. Date signed 3/20/45

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

*Olga Medical Bldg*

**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: *Olga Medical Bldg*

Licensed Embalmer No. *1467*

P. O. Address. *Davenport City*

**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.**