

No. 2
-2-43
17-39
X25697

FILED APR 21 1945

State File No. _____

Registration District No. 72

Primary Registration District No. 4134

Registrar's No. 19

1. PLACE OF DEATH:

(a) County CLAY
(b) City or town SMITHVILLE, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution SMITHVILLE COMMUNITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 DAYS
In this community LIFETIME years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County CLAY
(c) City or town SMITHVILLE, R.F.D.
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? NO
If yes, name country _____ (Yes or No)

3. (a) PRINT FULL NAME JESSE LEVI HORNBACK

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 MARRIED

6. (b) Name of husband or wife DEE DOUGLAS HORNBACK 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased APR. 25 1892
(Month) (Day) (Year)

8. AGE: Years 52 Months II Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation FARMER

11. Industry or business _____

12. Name PETER GILMORE HORNBACK

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

14. Maiden name SARAH GREEN
15. Birthplace PLATTE COUNTY, MO.
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. J. L. HORNBACK

(b) Address SMITHVILLE, MO. R.F.D.

17. (a) BURIAL (b) Date thereof 4/4/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SMITHVILLE, MO.

18. (a) Signature of funeral director McGowan Funeral Home

(b) Address Smithville, Mo.

19. (a) Apr 5-1945 (b) Ruth N Henry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR. day 1st
year 1945 hour 9:30 minute p. M.

21. I hereby certify that I attended the deceased from 3-29-45 1945 to 4-1-45 1945
that I last saw him alive on April 1-1945 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Septicemia
Due to infection in left eye.

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident

(b) Date of occurrence 3-19-45

(c) Where did injury occur? Smithville Mo.
(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) _____

Means of injury struck in eye by stick

23. Signature [Signature] (M.D. or other) _____

Address Smithville Mo. Date signed 4-3-45

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

1021

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 4/19/45

MAY 4 1945

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

S. R. McCombs

Licensed Embalmer No.

2303

P. O. Address

Smithville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. 190

Registration District No. 72 Primary Registration District No. 4134

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Smithville
(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)

3. (a) PRINT FULL NAME Jesse L. Hombach
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 23 1945
(Month) (Day) (Year)

8. AGE: Years 52 Months 11 Days _____ If less than one day _____ min.
MO

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Clay
(c) City or town Smithville Mo
(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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April Day 1 Year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from March 19 to April 1, 1945
that I last saw her alive and that death occurred on the date and hour stated above.
Immediate cause of death Septicemia following penetrating injury to left eye

Due to _____ Duration 12 days
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 240

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) Accident

(b) Date of occurrence March 18-1945

(c) Where did injury occur? Smithville Mo. clay
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On his farm

While at work? No (Specify type of place) (e) Means of injury _____

23. Signature JBA/ob (M. D. or other) MA

Address Smithville Mo Date signed 4-26-45

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

SUPPLEMENTAL

13166