DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 14 1945

State File No. 23582

Registration District No. 44 Primary Registration District No. 4060 Registrar's No. 17

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

1. PLACE OF DEATH:
(a) County CALDWELL
(b) City or town BRECKENRIDGE (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 60 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County CALDWELL
(c) City or town BRECKENRIDGE (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 JAMES HENRY HORNBACK
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex O
5. Color or race
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife RACHEL HORNBACK
6. (c) Age of husband or wife if alive years
7. Birth date of deceased JUNE (Month) 30 (Day) 1852 (Year)

8. AGE: Years 93 Months Days 29 If less than one day hr. min.

9. Birthplace GREENVIEW (City, town, or county) ILL (State or foreign country)
10. Usual occupation RETIRED FARMER
11. Industry or business
FATHER
12. Name ANDREW-HORNBACK
13. Birthplace (City, town, or county) IND (State or foreign country)
MOTHER
14. Maiden name MAHALA-POWEL
15. Birthplace (City, town, or county) IND. (State or foreign country)
16. (a) Informant Mrs Link Brewer
(b) Address Breckenridge
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill Cemetery
18. (a) Signature of funeral director T. McCuk
(b) Address Breckenridge Mo.
19. (a) Aug 2-1945 (Date received local registrar) (b) E A Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 29 year 1945 hour 1 PM minute ~~10~~ M.
21. I hereby certify that I attended the deceased from July 20 July 1945 to July 29 1945 that I last saw him alive on July 29 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Anaemia	1 Mo.
Due to Old age	
Due to 162 b	
Other conditions (Include pregnancy within 3 months of death) E A Thompson	
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 E A Thompson (M. D. or other)
Address Breckenridge Mo. Date signed

1151 (Licensed Embalmer's Statement on Reverse Side) July 29 ~~Aug 2~~-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.....

Licensed Embalmer No.....

P. O. Address.....

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.

No. 2B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 14 1945

State File No. 77

Registration District No. 44 Primary Registration District No. 4060 Registrar's No.

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Breckenridge
(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 years, months or days)
In this community

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 James H. Hornbach

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 Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 30 (Month) (Day) 1875 (Year)

8. AGE: Years 93 Months 2 Days 26 If less than one day hr. min.

9. Birthplace (City, town, or county) Ill. (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 9 year 1945 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

23582