

No. 2
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DEPARTMENT OF COMMERCE, THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS

FILED Jul 8 1946
Registration District No. 286

STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 4424

State File No. 21146
Registrar's No.

1. PLACE OF DEATH:
(a) County Polk
(b) City or town Humansville, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Geo. Dimmitt Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Emily Florence Hornbeck
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 / 5. Color or race w. 6. (a) Single, widowed, married, divorced w.
6. (b) Name of husband or wife Robert Hornbeck 6. (c) Age of husband or wife if alive deceased years
7. Birth date of deceased Oct 5 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 6 12 hr. min.

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

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER
12. Name John Smith 9
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Matilda Gilmore
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Hornbeck
(b) Address Humansville, Mo. Rte 3

17. (a) Burial (b) Date thereof 6-18-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Union Cemetery

18. (a) Signature of funeral director Charles F. Neale

(b) Address Stackton Mo.

19. (a) June 25, 1946 (b) Luille Kikpatrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cedar 20
(c) City or town Rural 0
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
year 1946 hour 9 minute 50 A. M.
21. I hereby certify that I attended the deceased from June 16
1946 to June 19 1946
that I last saw her alive on June 17 1946
and that death occurred on the day and hour stated above.

Immediate cause of death Carcinoma of Liver.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: metastatic carcinoma of ascending colon & abscess formation
Of operations _____
Of autopsy _____

Duration _____
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? _____

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

23. Signature G. H. Robinson (M. D. or other) MD
Address Humansville, Mo. Date signed 6/14/46

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

262

RECEIVED

District Office No. 7,

Index File No. 6-46-663

Date Filed 7-3-46

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. _____

Registration District No. 286 Primary Registration District No. 4424

1. PLACE OF DEATH: Polk
(a) County _____
(b) City or town. Humanville
(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

3. (a) PRINT FULL NAME Emily J. Humberch
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 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 Oct 5
(Month) (Day) (Year)

8. AGE: Years 86 Months 6 Days _____ If less than one day hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
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 _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I had seen _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Ascending Colon
Due to _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

20015

21146