

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

33560

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4211

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. MARY'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 MONTHS & 4 DAYS
(Specify whether years, months or days)
In this community SAME

2. USUAL RESIDENCE OF DECEASED:

(a) State KANSAS (b) County MIAMI
(c) City or town OSAWATOMIE
(If outside city or town limits, write "RURAL")
(d) Street No. 1136 WALNUT, ST.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME TRABER H. HORN

3. (b) If veteran, name war NO 3. (c) Social Security No 702-14-8948

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ANNA HORN 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased OCT. 1 - 1888
(Month) (Day) (Year)

8. AGE: Years 58 Months 0 Days 3 If less than one day hr. _____ min. _____

9. Birthplace MIAMI COUNTY KANSAS
(City, town, or county) (State or foreign country)

10. Usual occupation MACHINIST HELPER

11. Industry or business M.O.P. R.R.

MOTHER FATHER { 12. Name DAYE HORN 9
13. Birthplace NOT KNOWN 9
(City, town, or county) (State or foreign country)
14. Maiden name ELIZABETH FOUTZ
15. Birthplace NOT KNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. ANNA HORN

(b) Address OSAWATOMIE, KANSAS

17. (a) REMOVAL (b) Date thereof OCT. 4-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OSAWATOMIE, KANSAS

18. (a) Signature of funeral director Stine McClure U. Co.
(b) Address 3235 Hillman Plaza 15. C. Mo.

19. (a) 10-5-46 (b) Gerardine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4th
year 1946 hour One minute 17 A. M.

21. I hereby certify that I attended the deceased from 7-29, 1946 to 10-4-46, 19____;
that I last saw him alive on 10-3-46, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure
Myocarditis, Chronic
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Duration

14R

3mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Of operations None 932
Of autopsy None

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 H. A. Buske (M. D. or other)
Address 1602 ARBYLE BLDG. Date signed 4 Oct 46

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

ON G. E. CARTER

(Licensed Embalmer's Statement on Reverse Side)

Dr. ~~Robert~~ ~~Reef~~
Body

OCT 18 1948

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 Robert N Reef

Licensed Embalmer No. 3745

P. O. Address. 11C, 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.