

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26499

Registration District No. 344

Primary Registration District No. 6160

Registrar's No. 20

1. PLACE OF DEATH

(a) County Stone

(b) City or town Rural - Ance Creek
(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 Entire Life
years, months or days

3. (a) PRINT FULL NAME John Horn

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex m 5. Color or race wh

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Elizabeth Horn

6. (c) Age of husband or wife if alive 8-1 years

7. Birth date of deceased Feb 23 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

81 3 16 hr. _____ min.

9. Birthplace Stone Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name John Horn

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

14. Maiden name Unknown

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

16. (a) Informant Marion Horn

(b) Address Reeds Springs

17. (a) Burial (b) Date thereof Feb 12 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nickerson

18. (a) Signature of funeral director Everett Cheatham

(b) Address Galena, Mo

19. (a) 6-11-1947 (b) Myrtle Goforth
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stone

(c) City or town Rural (Ance Creek TP)
(If outside city or town limits, write "RURAL")

(d) Street No. 10 mi. S.W. Reeds Spring
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 8
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on April - 26th - 47, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis, and senility.

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? _____

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

23. Signature W.P. Cottrell (M. D. or other) xxx

Address Reeds Spring, Mo. Date signed _____

RECEIVED

District Health Officer No. 6,

District File Number 747-728

Date Filed JUN 2 1947

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 Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Galena 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.