

FILED SEP 24 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32278

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8085

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1900 Mitchell Pl.		d. STREET ADDRESS (If rural, give location) 1900 Mitchell Pl.	

3. NAME OF DECEASED (Type or Print) a. (First) MARTHA b. (Middle) J. c. (Last) VANHORNE			4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1949		
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5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Sept. 2, 1853		9. AGE (In years last birthday) 96		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Edina Mo.				12. CITIZEN OF WHAT COUNTRY? D	

13a. FATHER'S NAME Wm. H. Hannah			13b. MOTHER'S MAIDEN NAME Clarissa Sharp			14. NAME OF HUSBAND OR WIFE Thos. J. VanHorne		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Thos. J. VanHorne Jr.		ADDRESS 1900 Mitchell St. Louis	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infirmities of age						11 yrs	
		ANTECEDENT CAUSES							
		MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b) Arthritis							
		DUE TO (c)							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 189 to Aug/ 49, 19, that I last saw the deceased alive on Aug. 49 19, and that death occurred at 7 P m., from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) Thos. J. VanHorne Jr. M.D.		23b. ADDRESS 7465 Hazel, Maplewood, Mo.		23c. DATE SIGNED 9/19/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9/20/49		24c. NAME OF CEMETERY OR CREMATORY Linnville Cem.		24d. LOCATION (City, town, or county) (State) Edina Mo.	
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DATE REC'D BY LOCAL REG. SEP 19 1949		REGISTRAR'S SIGNATURE J.B. L... ..		25. FUNERAL DIRECTOR'S SIGNATURE Jay B. Smith		ADDRESS 7456 Manchester Rd. Maplewood, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed *J. Allen Davis*
Licensed Embalmer No. *4083*
P. O. Address *Albany, 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.