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FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35239  
State File No. 9411

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (If deceased lived. If institution: residence before admission.) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS MO 1</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5315 ALFRED</b>		d. STREET ADDRESS (If rural, give location) <b>15-5315 ALFRED</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>JACOB</b>	b. (Middle) <b>-</b>	c. (Last) <b>HORN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>OCT. 30 1949</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JAN. 12 1878</b>	9. AGE (In years last birthday) if UNDER 1 YEAR Months Days if UNDER 4 HRS. Hours Min. <b>71 9 17</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED DAY LABORER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>MATHIAS HORN</b>	13b. MOTHER'S MAIDEN NAME <b>BARBARA JUNKER</b>	14. NAME OF HUSBAND OR WIFE <b>SADIE HORN</b>
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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.	17. INFORMANT'S SIGNATURE OR NAME <b>KATHERINE REICHARD</b>	ADDRESS <b>5315 ALFRED</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pericarditis with Obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>1 year</b> <b>1 year</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>not T.B. Myocarditis - Pulmonary Fibrosis Chronic</b>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>None</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>114</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>None</b>
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22. I hereby certify that I attended the deceased from **January 2, 1949**, to **October 30, 1949**, that I last saw the deceased alive on **Oct 29, 1949**, and that death occurred at **11:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Scott Heuer, M.D.</b>	(Degree or title)	23b. ADDRESS <b>634 N. Grand Blvd. St. Louis, Mo</b>	23c. DATE SIGNED <b>10-31-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>Nov. 2 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>
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DATE REC'D BY LOCAL REG. <b>NOV 1 1949</b>	REGISTRAR'S SIGNATURE <b>J. B. Sasater</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Kutis</b>	ADDRESS <b>2906 Travis</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*He is a student*

**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 *James C. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2906 Shaw*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.