

FILED JAN 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41832

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 237 PRIMARY REG. DIST. NO. 4353 Registrar's No. 22

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>New Madrid</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gideon</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gideon</u> | |
| c. LENGTH OF STAY (in this place) <u>4 yrs.</u> | | 72 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u> | | d. STREET ADDRESS (If rural, give location) <u>1</u> | |

| | | | | |
|---|------------|-------------|-----------------------|--|
| 3. NAME OF DECEASED (Type or Print) <u>Mittie</u> | a. (First) | b. (Middle) | c. (Last) <u>Horn</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 26, 1949</u> |
|---|------------|-------------|-----------------------|--|

| | | | | | | | |
|----------------------|-------------------------------|---|--------------------------------------|---|-----------------|----------------|--|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Feb 24, 1879</u> | 9. AGE (In years last birthday) <u>70</u> | MONTHS <u>9</u> | YEARS <u>2</u> | IF UNDER 1 YEAR Hours <u></u> Min. <u></u> |
|----------------------|-------------------------------|---|--------------------------------------|---|-----------------|----------------|--|

| | | | |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|--|---|--|

| | | |
|------------------------------------|---|--------------------------------------|
| 13a. FATHER'S NAME <u>un known</u> | 13b. MOTHER'S MAIDEN NAME <u>un known</u> | 14. NAME OF HUSBAND OR WIFE <u>-</u> |
|------------------------------------|---|--------------------------------------|

| | | | | |
|---|--|-------------------------------------|---|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Ruth Abernathy - Gideon, Mo.</u> | ADDRESS |
|---|--|-------------------------------------|---|---------|

| | | | |
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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. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cerebral hemorrhage</u> | | <u>3 days</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> | | <u>10 years</u> |
| DUE TO (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | <u>331X</u> |

| | | |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|---|

| | | |
|--|--|---|
| 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) |
|--|--|---|

| | | |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from Sept 1946 to Nov 25, 1949, that I last saw the deceased alive on 11-25, 1949 and that death occurred at 2:00 PM from the causes and on the date stated above.

| | | | |
|---|-------------------|---------------------------------|---------------------------------|
| 23a. SIGNATURE <u>J. J. Hopkins, M.D.</u> | (Degree or title) | 23b. ADDRESS <u>Gideon, Mo.</u> | 23c. DATE SIGNED <u>12-5-49</u> |
|---|-------------------|---------------------------------|---------------------------------|

| | | | |
|---|------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Nov 28 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Shumach Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Holcomb, Mo. Rt. 1</u> |
|---|------------------------------|--|---|

| | | | |
|---|--|---|---------|
| DATE REC'D BY LOCAL REG. <u>12-7-49</u> | REGISTRAR'S SIGNATURE <u>Mr. Byron Sharp</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wendell Funeral Home, Campbell, Mo.</u> | ADDRESS |
|---|--|---|---------|

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

12
10

RECEIVED JAN 9
District Health Office
District File Number 156-
Date Filed

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 *Christine M. Landers*

Licensed Embalmer No. *4227*

P. O. Address *Campbell, Md*

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.