

FILED JUL 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24897

State File No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 5980	
1. PLACE OF DEATH a. COUNTY St. Louis-Mo				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) 2119		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital	
3. NAME OF DECEASED (Type or Print) a. (First) Fannie b. (Middle) _____ c. (Last) Horton				4. DATE OF DEATH (Month) (Day) (Year) July 10 1950			
5. SEX Female		6. COLOR OR RACE Obl		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Feb 14.1867	
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months 4		IF UNDER 2 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) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME Martin Harris	
13b. MOTHER'S MAIDEN NAME Caroline Harris		14. NAME OF HUSBAND OR WIFE Edward Horon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME -- ADDRESS Martin Franice 4227/w Labadie Ave					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congestive Failure DUE TO (c) Malnutrition				INTERVAL BETWEEN ONSET AND DEATH Undet.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 (Month) (Day) (Year) (Hour) (Minute) OF INJURY _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H200					
22. I hereby certify that I attended the deceased from 7-4 , 1950, to 7-10 , 1950, that I last saw the deceased alive on 7-10 , 1950, and that death occurred at 12:15a m., from the causes and on the date stated above.							
23a. SIGNATURE Alvin J. Thompson (Degree or title) M. D.				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 7-11-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/12/450		24c. NAME OF CEMETERY OR CREMATOR Jefferson Barracks		24d. LOCATION (City, town, or county) (State) Jefferson Mo	
DATE REC'D BY LOCAL REG. JUL 11 1950		REGISTRAR'S SIGNATURE J. B. Fasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman J. Smith 4247/w Labadie			

(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Lawrence E. Erickson

Signed.....
Student Embalmer

Licensed Embalmer No. 4341

P. O. Address St. Louis 13, 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.