

FILED DEC 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36210

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1364

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph 0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1519 eFaraon eSt.,		d. STREET ADDRESS (If rural, give location) 1519 Faraon St. 0	

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Aittie Ann Horn			4. DATE OF DEATH (Month) (Day) (Year) Nov. 19, 1950			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 6/3/1860	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house Wife		10b. KIND OF BUSINESS OR INDUSTRY house Wife		11. BIRTHPLACE (State or foreign country) Buchanan CO. Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Reuben Horn-	13b. MOTHER'S MAIDEN NAME Martha Willa	14. NAME OF HUSBAND OR WIFE Deceased (Samuel)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Ulah Clevenger	ADDRESS St. Joseph Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4500
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ## DUE TO (c) ##		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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 1st, 1950, to Nov 19th, 1950, that I last saw the deceased alive on Nov 19th, 1950 and that death occurred at 1 P. m., from the causes and on the date stated above.

23a. SIGNATURE A. W. Tadlock (Degree or title)	23b. ADDRESS King Hill Bldg, St Joseph, Mo.	23c. DATE SIGNED 11/25
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 11/21/50	24c. NAME OF CEMETERY OR CREMATORY Hebron Cem.
		24d. LOCATION (City, town, or county) Gower Mo.

DATE REC'D BY LOCAL REG. Dec 6, 1950	REGISTRAR'S SIGNATURE Carl E. Casper	446	25. FUNERAL DIRECTOR'S SIGNATURE John H. Murray	ADDRESS Gower 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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John H. Murray

Licensed Embalmer No.

2893

P. O. Address

Gower, 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.