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

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

13468
 State File No.
 Registrar's No. 3225

FILED MAY 9 1955
 BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION Incarinate Word Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis c. CITY OR TOWN Velda Village 4/60 d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> STREET ADDRESS (If rural, give location) 6500 Myron Ave., Velda Village	
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3. NAME OF DECEASED (Type or Print) Merie J. Hornecker a. (First) Merie b. (Middle) J. c. (Last) Hornecker			4. DATE OF DEATH (Month) (Day) (Year) April 9, 1955		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 11, 1898	9. AGE (In years last birthday) 56 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 (City and State or Foreign Country) St. Louis, Missouri	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME William Kramer	13b. MOTHER'S MAIDEN NAME Emma A. Kramer	14. NAME OF HUSBAND OR WIFE Matthew J. Hornecker
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. 489-01-0773	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Matthew J. Hornecker 6500 Myron 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, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of lungs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cancer of left breast 20 mos. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 8 weeks
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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) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 170X

22. I hereby certify that I attended the deceased from 20 Dec 54, 1954, to 9 Apr, 1955, that I last saw the deceased alive on 9 Apr, 1955, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) S. Dworkin MD	23b. ADDRESS 1657 So Grand	23c. DATE SIGNED 11 Apr 55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 12, 1955	24c. NAME OF CEMETERY OR CREMATORY S/S Peter & Paul
24d. LOCATION (City, town, or county) (State) 7030 Gravois, St. Louis, Mo		

DATE REC'D BY LOCAL REG. APR 11 1955	REGISTRAR'S SIGNATURE J. Carl Smith MD <i>mjs</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser's 4228 S. Kingshighway
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed..... *William E. White*.....
Licensed Embalmer No. *429*

P. O. Address *4229 N. Kingsley*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.