

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25032

STATE FILE NUMBER

FILED JUL 20 1956

318

1003

5957

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MISSOURI COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN	
ST. LOUIS, MISSOURI		Yes <input type="checkbox"/> No <input type="checkbox"/>		ST. LOUIS	
c. FULL NAME OF HOSPITAL OR INSTITUTION		Length of stay in lb		d. STREET ADDRESS	
ST. LOUIS CITY HOSPITAL #1.		23		1809 Dolman	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last MICHAEL WAYNE HORN			Month Day Year JUNE 22, 1956		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-3-1949	6	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
None		None		St. Louis, Missouri	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
James E. Horn			U.S.A.		
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 Address	
No		NONE		Mary Horn, 1809b Dolman	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					INTERVAL BETWEEN ONSET AND DEATH
Pulmonary edema due to					
Congestive Failure					
Acute Lymphoblastic Leukemia					
(present since Sept 1955)					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
					2040
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 12/27/55 to 6/22/56 and last saw her alive on 6/22/56					
Death occurred at 1:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title)			22b. ADDRESS		22c. DATE SIGNED
<i>Carl Smith, M.D.</i>			1515 LAFAYETTE AVE.		6/22/56.
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL	
Removal		6-25-1956		Memorial Park Ceme.	
				St. Louis County, Missouri	
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE
McLAUGHLIN F.H., INC. Lafayette			JUN 23 1956		<i>Carl Smith - M.D.</i>

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
[Handwritten Signature]

Licensed Embalmer No.....

P. O. Address.....
[Handwritten Address]

22/10/57

22/10/57

22/10/57

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (I
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.