

Health, Welfare, Public Service  
 300  
 1-56  
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 ALL symptoms will be listed. All  
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FILED OCT 16 1956

STANDARD CERTIFICATE OF DEATH

35658

STATE FILE NUMBER

8566

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Desloge Hospital</b>				Length of stay in lb		STREET ADDRESS <b>4803 Minnesota</b> (If outside, give location) <b>2159</b>		
3. NAME OF DECEASED (Type or print) <b>Lucy</b>			First <b>Lucy</b> Middle <b>Hornback</b> Last <b>Hornback</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>14,</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1877</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Charleston, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ernest Green, 4803 Minnesota</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> DUE TO (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis-generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
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 <b>7:15</b> Month <b>Sept</b> Day <b>14</b> Year <b>1956</b> a. m. <b>P.</b> 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 <b>Sept 14, 1956</b> to <b>Sept 14, 1956</b> and last saw her <b>alive</b> on <b>Sept 14, 1956</b> Death occurred at <b>7:15 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Ernest B. Subel MD</b>					22b. ADDRESS <b>16 Hampton Village</b>		22c. DATE SIGNED <b>9/15/56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-15-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>Charleston, Mo.</b>			
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>SEP 17 1956</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 embalmed  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*John Haines*

Licensed Embalmer No. *411*

P. O. Address *St. Louis*

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