

Health, Welfare
Public Service

300
-56

ALL diseases in Part I must be causally related. Caregiver cannot certify to a death due to natural causes. No symptoms will be listed. No standard nomenclature in them is. Doctor, coroner, etc. must use only standard nomenclature in them is.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35660

STATE FILE NUMBER

FILED NOV 16 1956

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8980

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1968 Belt Ave.			Length of stay in lb		STREET ADDRESS 1968 Belt Ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Fred Middle Carl Last Horning				4. DATE OF DEATH Month 9- Day 29 Year 56					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 29, 1890		9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaper			10b. KIND OF BUSINESS OR INDUSTRY Landscaper		11. BIRTHPLACE (City and state or country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Horning				14. MOTHER'S MAIDEN NAME Doris Pape					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. #1			16. SOCIAL SECURITY NO. 497-07-7757		17. INFORMANT Mrs. Clara Nix			Address 4619 Shirley Pl.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Ruptured esophageal Varix DUE TO (b) 2. Cirrhosis of liver DUE TO (c) 3. Ascites Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 581.0		
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 Month, Day, Year 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 _____, to _____ and last saw her/him alive on _____ Death occurred at 2:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE James M. Kelly (Degree Physician)				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 10-1-56			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-3-56		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Missouri			
24. FUNERAL DIRECTOR Jos. W. Clark F. H. Inc. 1125 Hodiamont				ADDRESS		25. DATE RECD. BY LOCAL REG. OCT 1 1956		26. REGISTRAR'S SIGNATURE Carl Smith MD	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(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.....
Licensed Embalmer No.....
P. O. Address.....

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.