

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23680

STATE FILE NUMBER

FILED JUL 22 1957

Registration District No. 42 Primary Registration District No. 5134 Registrar's No. 752

| | | | |
|---|--|--|---|
| 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, give TOWNSHIP only) OR TOWN Washington Twp. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN St. Joseph Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RFD # 4 | | d. STREET ADDRESS RFD # 4 (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First James Middle Elliott Last Hornbuckle | | 4. DATE OF DEATH Month July Day 11 Year 1957 | |
| 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 Mar. 12, 1883 |
| 9. AGE (In years last birthday) 74 | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming | |
| 11. BIRTHPLACE (City and state or country) Platte Co. Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Harden Hornbuckle | | 14. MOTHER'S MAIDEN NAME Sarah Ada Williams | |
| 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. None | |
| 17. INFORMANT Miss Ada Hornbuckle | | Address RFD 4 St Joseph | |
| 18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 30 min 4:00 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 4 201 | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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 7-9-57 to 7-11-57 and last saw her/him alive on 7-9-57 Death occurred at 4 p m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Name or title) Clemens E. Sherman M.D. | | | 22b. ADDRESS St Joseph Mo |
| 22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery | | | 22d. DATE SIGNED 7-12-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE July 15, 1957 | 23c. LOCATION (City, town, or county) (State) Easton, Mo. | |
| 24. FUNERAL DIRECTOR Herman W. Sidenfaden | ADDRESS St Joseph, Mo | 25. DATE RECD. BY LOCAL REG. July 16, 1957 | 26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes. Part I must be causally related. Diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by Student Embalmer No.

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Robert G. Gayer

Licensed Embalmer No. 330

P. O. Address St. Joseph

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.