

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1895

STATE FILE NUMBER

FILED JAN 22 1958

Registration District No. 179

Primary Registration District No. 5671

Registrar's No. 61

1. PLACE OF DEATH a. COUNTY <u>LINCOLN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>LINCOLN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>TRUSTON</u>		c. CITY OR TOWN <u>TRUSTON</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u>		d. STREET ADDRESS (If outside, give location) <u>HOME</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES LESLIE HORTON</u>			4. DATE OF DEATH Month Day Year <u>1-13-58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1898</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days <u>0 0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Team operator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Warren County mo</u>	

13a. FATHER'S NAME <u>James Horton</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Davidson</u>		14. NAME OF HUSBAND OR WIFE <u>Katherine Horton</u>	
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. <u>333-03-1813</u>		17. INFORMANT Address <u>Katherine Horton Truston mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
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) <u>4201</u>			

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 p.m.					

20d. INJURY OCCURRED WHILE AT <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 <u>1/13/58</u> to <u>Expired on arrival</u> Death occurred at <u>16130 17</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>H. S. Davidson</u> (Degree or title)			22b. ADDRESS <u>Truston mo.</u>		22c. DATE SIGNED <u>1/14/58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-15-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Florence</u>		23d. LOCATION (City, town, or county) (State) <u>New Florence mo</u>
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24. FUNERAL DIRECTOR <u>Ed Harding</u>		ADDRESS <u>Truston mo</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 17 1958</u>	26. REGISTRAR'S SIGNATURE <u>Nell-S. Schoenhein</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 2 1958

APR 9 1958

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 *Carl A. Dardinger*

Licensed Embalmer No. *4115*
P. O. Address *Jonestown, Md.*

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.