

health, Welfare public service
 300 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY 8 1958

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-015945

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **AG70**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY Graves						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Mayfield		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Length of stay in 1b		33 STREET ADDRESS Paducah Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First COLEN Middle Carnell Last HORN				4. DATE OF DEATH Month April Day 26 Year 1958						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1908		9. AGE (In years last birthday) 49 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milk Receiver			10b. KIND OF BUSINESS OR INDUSTRY Pet Milk Co.		11. BIRTHPLACE (City and state or country) Graves Co., Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Monroe Horn				14. MOTHER'S MAIDEN NAME Julia Carter						
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. Unknown		17. INFORMANT Glays Horn, Mayfield, Ky.			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) massive pulmonary embolism								INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) glioblastoma -								
		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 checked="" type="checkbox"/> NO <input type="checkbox"/> 1		
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.)						1939	
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 4/15/58 to 4/26/58 and last saw ^{her} him alive on 4/26/58 Death occurred at 7:10 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <i>F. Bradley</i>				(Degree or title) O M. D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 4/27/58		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-27-58		23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery			23d. LOCATION (City, town, or county) (State) Mayfield, Ky.			
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.				ADDRESS		25. DATE RECD. BY LOCAL REG. APR 30 '58		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> m8B		

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 *Wm P. Dunblay*

Licensed Embalmer No. *36*

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.