Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-021202

STATE FILE NUMBER

FILED JUL 1 1958 Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY: CASS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: HARRISONVILLE — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: MEMORIAL Hospital — Length of stay in Ib: 24 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY: Cass
c. CITY OR TOWN: Harrisonville 0191 0 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 401 E Washington — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: SPENCER Middle: TOM Last: HORNER

4. DATE OF DEATH: Month: June Day: 19 Year: 1958

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 25, 1903
9. AGE (In years last birthday): 55 — 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): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Beatrice, Nebr.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Abe Horner
13b. MOTHER'S MAIDEN NAME: Jessie Little
14. NAME OF HUSBAND OR WIFE: Helen L. Horner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 496-07-2222
17. INFORMANT: Helen L. Horner Address: Hill, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 48 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): ETIOLOGY UNDETERMINED
DUE TO (c): 331X
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 [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 JUNE 18 1958, to JUNE 19 1958 and last saw him alive on JUNE 19 1958
Death occurred at 12:30 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: H. Woody M.D. (Degree or title) 0
22b. ADDRESS: HARRISONVILLE Mo
22c. DATE SIGNED: 6-21-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/22/58
23c. NAME OF CEMETERY OR CREMATORY: Freeman Cemetery
23d. LOCATION (City, town, or county) (State): Freeman, Mo.

24. FUNERAL DIRECTOR: Kennenburger's ADDRESS: Harrisonville
25. DATE RECD. BY LOCAL REG.: June 21, 1958
26. REGISTRAR'S SIGNATURE: Dora Barnard

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

RECEIVED
JUN 30 1958
CASS COUNTY
HEALTH DEPARTMENT

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 James R. Phillips

Licensed Embalmer No. 4641

P. O. Address Harrisonville

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.