

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035820  
STATE FILE NUMBER

FILED NOV 14 1958 Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 144

1. PLACE OF DEATH a. COUNTY <i>Clay</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, give place before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY OR TOWN <i>Smithville</i> <small>(If outside corporate limits, give TOWNSHIP only)</small>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR HEALTH CARE FACILITY <i>Smithville Hospital</i>		Length of stay in 1b <i>608</i>	d. STREET ADDRESS (If outside, give location) <i>6500 N. Mc Lee</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Edna</i> Middle <i>Selata</i> Last <i>Hornbuckle</i>			4. DATE OF DEATH Month <i>11</i> Day <i>6</i> Year <i>1958</i>			
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March-29-1899</i>	9. AGE (In years last birthday) <i>81</i>	IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>	IF UNDER 24 HRS. Hours <i>-</i> Min. <i>-</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTHPLACE (City and state or country) <i>Calloway Co. Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Thomas Sanders</i>	13b. MOTHER'S MAIDEN NAME <i>Selata Drinkard</i>	14. NAME OF HUSBAND OR WIFE <i>Walter A. Hornbuckle</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>Mrs. Velma Nichols</i> Address <i>K.C. Mo.</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia right lung</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Weakness in anemia + malnutrition</i>		<i>1 yr or more</i>
	DUE TO (c) <i>Carcinoma of Stomach</i>		<i>1 yr or more</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>151X</i>		18 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.) <i>151X</i>
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20c. TIME OF INJURY Hour <i>-</i> Month <i>-</i> Day <i>-</i> Year <i>-</i> a.m. <i>-</i> p.m. <i>-</i>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION <i>151X</i>	COUNTY	STATE
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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 <i>151X</i>	COUNTY	STATE
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21. I attended the deceased from *6-9-58* to *11-6-58* and last saw <sup>her</sup> alive on *11-6-58*  
Death occurred at *1:50 a.m.* on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Ronald E. Greer, M.D.</i>	22b. ADDRESS <i>Washland 3rd St 1</i>	22c. DATE SIGNED <i>11-6-58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Nov-8-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Kansas City, Mo.</i>
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24. FUNERAL DIRECTOR <i>C. H. Blackman &amp; Son</i>	ADDRESS <i>2nd St</i>	25. DATE RECD. BY LOCAL REG. <i>11-7-58</i>	26. REGISTRAR'S SIGNATURE <i>Marguerite Hudgens</i>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *W. C. Benine* .....

Licensed Embalmer No. *4879* .....  
P. O. Address *W. C. Benine* .....

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.