

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039113

STATE FILE NUMBER

FILED DEC 15 1958

Registration District No.

47

Primary Registration District No.

3008

Registrar's No.

270

S. 300
1-57

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY CALLAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY TEXAS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FULTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ELK CREEK Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. HOSPITAL #1		Length of stay in lb 3 years	d. STREET ADDRESS (If outside, give location) 1070 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ARTHUR Middle H. Last HORNER			4. DATE OF DEATH Month 12 - Day 5 - Year 1958
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 1-1-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (City and state or country) TENNESSEE
13a. FATHER'S NAME LUTHER HORNER		13b. MOTHER'S MAIDEN NAME LUCINDA HAMPTON	14. NAME OF HUSBAND OR WIFE 1
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT ST. HOSPITAL #1, FULTON, MISSOURI 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) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Right Bundle Branch Block DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diarrhea			INTERVAL BETWEEN ONSET AND DEATH 4200
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 _____ a.m. _____ p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. Attended the deceased from 11/2/1955 to 12/5/1958 and last saw him xxxxxxx Death occurred at 8:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harold G. Freund, M.D.		22b. ADDRESS St. Hospital No. 1	22c. DATE SIGNED 12/5/58
23a. BURIAL CREMATION REMOVAL (Specify) Removal	23b. DATE 12-8-58	23c. NAME OF CEMETERY OR CREMATORY anatomical road Columbia mo	23d. LOCATION (City, town, or county) (State) Columbia mo
24. FUNERAL DIRECTOR J. O. Roberts Columbia mo		25. DATE RECD. BY LOCAL REG. Dec 8. 1958	26. REGISTRAR'S SIGNATURE Marretta Lawrence

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

Licensed Embalmer No.

P. O. Address

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.