

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043372
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 712

300
1-57

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Essex 10 30 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Doctor's Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Jesse Middle Horn Last Horn			4. DATE OF DEATH Month Dec. Day 27 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 Aug. 2, 1904	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months 4 Days 25	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Strawberry, Arkansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	-----------------------------------	---	---

13a. FATHER'S NAME Frank M. Horn	13b. MOTHER'S MAIDEN NAME Lucinda Croom	14. NAME OF HUSBAND OR WIFE Alie Horn
--	---	---

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.	17. INFORMANT Address Mrs. Alie Horn, Essex, Missouri
---	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic heart disease	unknown
	DUE TO (c) 4200	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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 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 Dec 23, 1958 , to Dec 27, 1958 and last saw him alive on Dec 26, 1958 Death occurred at 11:20 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Robert Engelhard MD (Degree or title)	22b. ADDRESS Poplar Bluff, Mo	22c. DATE SIGNED Dec 30, 1958
--	---	---

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-31-58	23c. NAME OF CEMETERY OR CREMATORY Ward	23d. LOCATION (City, town, or county) Strawberry, Arkansas (State)
--	------------------------------	---	--

24. FUNERAL DIRECTOR Strickland-Rainey ADDRESS Dexter, Mo.	25. DATE RECD. BY LOCAL REG. 12/27/58	26. REGISTRAR'S SIGNATURE R. Munster
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

89
0

SEP 6 1961

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 *Lucille Paisley* Licensed Embalmer No. *4983*

P. O. Address *Dexter, Mo.*

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.