Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007886
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 317 Primary Registration District No. 543 Registrar's No. 520

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN Jennings (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 5730 Janet Ave. Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Jennings 4148 Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 5730 Janet Ave Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: ANNA Middle: Last: HORMAN
4. DATE OF DEATH Month: Feb. Day: 20 Year: 1959
5. SEX female
6. COLOR OR RACE white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH Jan. 28, 1889
9. AGE (In years last birthday) 70 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) housework
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (City and state or country) St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Albert Marthaler
13b. MOTHER'S MAIDEN NAME Frances Wilmes
14. NAME OF HUSBAND OR WIFE Joseph Horman
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. none
17. INFORMANT Caroline Kramer Address 2625 Pamplin Ave.

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) Unknown natural causes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7954
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John C. Murphy M.D. (Degree or title) 22b. ADDRESS John C. Murphy MD Acting Health Commissioner 801 S. Brentwood Clayton
22c. DATE SIGNED 2/16/59

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 2/25/59
23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens
23d. LOCATION (City, town, or county) St. Louis County (State) Mo.

24. FUNERAL DIRECTOR Buchholz Mortuary ADDRESS 5967 W. Florissant
25. DATE RECD. BY LOCAL REG. 2-24-59
26. REGISTRAR'S SIGNATURE John C. Murphy, MD/jm

(Licensed Embalmer's Statement on Reverse Side)

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 Herbert J. Lear Jr.

Licensed Embalmer No. 7800

P. O. Address Kirkwood 227

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.