

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021438

FILED JUN 24 1959 Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 2772 Registrar's No. 2772

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>Research Hospital</u>		Length of stay in lb. <u>25 years</u>	d. STREET ADDRESS (If outside, give location) <u>6107 E. 55th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>J</u> Last <u>HORN</u> Jr.			4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 13, 1892</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired meat cutter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Meat</u>	11. BIRTHPLACE (City and state or country) <u>Skidmore, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Marshall Horn</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Robbins</u>		14. NAME OF HUSBAND OR WIFE <u>Myrtle Horn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>19-509-1807</u>	17. INFORMANT Address <u>Myrtle Horn - 6107 E. 55th St</u>			
18. CAUSE OF DEATH (Enter only one cause per life for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe uremia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>three months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Benign chronic prostatic hypertrophy with chronic glomular nephritis.</u>					<u>three months.</u>
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary insufficiency</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>610X</u>				
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>3-13-59</u> to <u>6-4-59</u> and last saw him alive on <u>6-4-59</u> Death occurred at <u>8:45</u> P on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ralph Perry M.D.</u>			22b. ADDRESS <u>4800 E. 24th, Kansas City, Mo.</u>		22c. DATE SIGNED <u>June 5, 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 8, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u>		
24. FUNERAL DIRECTOR <u>Kelba Funeral Home 2315 Lenwood</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-6-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Ralph Perry

All diseases in Part I must be causally related.

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 *Chas E. Wells*

Licensed Embalmer No. *2644*

P. O. Address *17 @ 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.