

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034792

FILED VS SEP 22 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2469

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Manchester, Mo.		c. CITY OR TOWN Manchester, Mo.	
Length of stay in 1b 15 yrs.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pine Crest Nursing Home		d. STREET ADDRESS (If outside, give location) Pine Crest Nursing Home	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Oliver Middle Hornburg Last Hornburg			4. DATE OF DEATH Month 9 Day 12 Year 59			
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 11/12/02	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY own		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Ernest Hornburg		13b. MOTHER'S MAIDEN NAME Louise Cummings		
14. NAME OF HUSBAND OR WIFE --		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. unk.		
17. INFORMANT Mrs. Clara Bachmann Ashbrook Dr.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH		

19. WAS AUTOPSY PERFORMED? YES <input 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.) Pulmonary Tuberculosis (arose)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		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		20g. COUNTY		20h. STATE	

21. I attended the deceased from March 1959 to 9-12-59 and last saw her alive on 9-8-59	
Death occurred at 3:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Allen McGeary	22b. ADDRESS 7308 Hesper
22c. DATE SIGNED 9-14-59	

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9/16/59	23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cem.	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Drehmann-Harral	ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. 9-14-59	26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MI. 5-1510

Hrs. 3:30 to 4 Mon. Tues.
After 12 noon

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 Warren A. Carver

Licensed Embalmer No. 3534

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.