

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028441

INDEXED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6467 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>	Length of stay in 1b <u>weeks</u>	c. CITY OR TOWN <u>Kirkwood</u>	Inside Limits Y <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1037 Whitecliff Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Fred Allan Horr</u>	First Middle Last	4. DATE OF DEATH <u>June 24 1960</u>	Month Day Year
---	-------------------	---	----------------

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>Sept. 23, 1891</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	---	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Purchasing Agent-Laclede Gas</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Horton Kansas</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>Frederick W. Horr</u>	13b. MOTHER'S MAIDEN NAME <u>Alice R. Smyser</u>	14. NAME OF HUSBAND OR WIFE <u>Lily B. Horr</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>493-09-6505</u>	17. INFORMANT <u>Lily B. Horr, Kirkwood, Mo.</u>	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) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>	
	DUE TO (c) <u>331 x H</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of lung</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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>None</u>
---	---	---

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 ---	COUNTY	STATE
--	---	-------------------------------------	--------	-------

21. I attended the deceased from 1942 to June 24, 1960 and last saw him live on 6-24-60.
Death occurred at 12/10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>19 E. Lockwood Ave., Webster Groves 19, Mo.</u>	22c. DATE SIGNED <u>6-25-60</u>
--------------------------------------	----------------------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6-27-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
---	-------------------------------	---	---

24. FUNERAL DIRECTOR <u>C.R. Lupton & Sons, St. Louis, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>JUN 25 1960</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
---	---------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(H.T.)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Arnold W. Sch

Licensed Embalmer No.

3864

P. O. Address

St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.