

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 10 1960 317

Registration District No. _____ Primary Registration District No. 500 Registrar's No. 2742 STATE FILE NUMBER 60-027047

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Crawford	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gardenville		Length of stay in 1b 4 Mo.	c. CITY OR TOWN Cuba Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Henninger Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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 Mary Middle Hornbeck Last Hornbeck			4. DATE OF DEATH Month 9 Day 15 Year 1960		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-8-1866	9. AGE (last birthday) 94	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Gottlieb Tebbe	13b. MOTHER'S MAIDEN NAME Wilhelmina Koch	14. NAME OF HUSBAND OR WIFE Adolph Hornbeck
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Edw. Hornbeck, Cuba, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH Several years
DUE TO (b) Arteriosclerosis -		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic cerebral vascular disease severe deformity of cervical & dorsal spine due to osteoarthritis; bronchopneumonia		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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
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21. I attended the deceased from May 19, 1960 to Sept 15, 1960 and last saw her ^{her} alive on Sept 10, 1960
Death occurred at 4:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wm. C. Council, M.D.	(Degree or title)	22b. ADDRESS 9264 Truman Ferry Rd. (231)	22c. DATE SIGNED 9/16/60
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23. BURIAL, CREMATION, or other disposition (Specify) REMOVAL	23b. DATE 9-17-1960	23c. NAME OF CEMETERY OR CREMATORY Old St. Marcus	23d. LOCATION (City, town, or county) (State) 6638 Gravois, St. Louis, Mo.
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24. FUNERAL DIRECTOR Riegenhein Bros	ADDRESS 6409 Gravois, St. L.	25. DATE RECD. BY LOCAL REG. 9-16-60	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Paul M. Seymour
Licensed Embalmer No. 4343

P. O. Address St. Louis

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