

FILED OCT 13 1961

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

=61-033676

STATE FILE NUMBER

Registration District No. 238 Primary Registration District No. 5823 Registrar's No. 19

V. S. 300
Rev. 1-57

0720

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kewanee</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kewanee</u> <u>0720</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>90</u>			Length of stay in lb <u>7 years</u>	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 <u>Lora</u> Middle <u>HORNBACK</u> Last <u>HORNBACK</u>				4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>61</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>2</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-61</u>		9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Olney, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Amos Lawless</u>			13b. MOTHER'S MAIDEN NAME <u>Cillah Bullard</u>			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) <u>No</u> <u>*****</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. H. C. Gill, Kewanee, Missouri.</u>			
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>Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____								
DUE TO (c) <u>493X</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac Decomposition @ Arteriosclerosis</u>							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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.								
20d. INJURY OCCURRED WHILE AT <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 _____, to _____ and last saw her alive on <u>oct 1959</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Charles Chubb, MD</u>				22b. ADDRESS <u>New Madrid, Mo</u>		22c. DATE SIGNED <u>2/5/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-25-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hayti, Missouri.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>John W. German Funeral Home, Hayti, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>10-2-61</u>		26. REGISTRAR'S SIGNATURE <u>Jay Hedgepeth</u>			

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

2-0

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 *John W. Germer*

Licensed Embalmer No. 4355

P. O. Address Hayti, Missouri.

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.