

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-012795

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3547**

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 12 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis Hospital</b>		Length of stay in lb <b>2 Days</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>319 West Gate Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Marylee</b> Middle <b>-</b> Last <b>Horner</b>			4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/9/1886</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Part-time Sales Lady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stix-Baer-Fuller</b>		11. BIRTHPLACE (City and state or country) <b>Columbia, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>William A. Horner</b>			13b. MOTHER'S MAIDEN NAME <b>Minerva Winans</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>Miss Nell C. Horner 319 West Gate Ave. 30</b> Zone <b>30</b>	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BASILAR SKULL FRACTURE, MIDDLE + POST. FOSSA.</b> Conditions, if any, which caused the above cause, stating the underlying cause. DUE TO (b) <b>SEVERE CEREBRAL CONCUSSION + CONTUSION</b> DUE TO (c) <b>EPIDURAL HEMATOMA, RIGHT SUBARACHNOID HEMORRHAGE 1. TEMPORAL</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>900.0 - 21</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b> <b>48 "</b> <b>48 "</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT <input checked="" 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.) <b>FELL DOWN STAIRS HIT HEAD.</b>	
20c. TIME OF INJURY Hour <b>8:15 p.m.</b> Month, Day, Year <b>MARCH 30, 1962</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>54 HOME</b>		20f. CITY, TOWN, OR LOCATION <b>ST. LOUIS</b>
20g. COUNTY <b>ST. LOUIS</b>		20h. STATE <b>MO.</b>				
21. I attended the deceased from <b>MARCH 3, 1962</b> to <b>APRIL 1, 1962</b> and last saw him alive on <b>APRIL 1, 1962</b> Death occurred at <b>8:15 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>George Hawkins, M.D.</b>			22b. ADDRESS <b>3720 Washington -</b>		22c. DATE SIGNED <b>APR 2-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Auto</b>		23b. DATE <b>April 4, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Columbia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Columbia Missouri</b>
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar</b>			25. DATE RECD. BY LOCAL REG. <b>APR 3 1962</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	

Dr. George Hawkins  
St. Lukes Hospital

**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 jos E McCallon

Licensed Embalmer No. 2466

P. O. Address 6175 Belmont

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.