

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9397-62-036279  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Register District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Length of stay in lb	c. CITY OR TOWN <b>Charleston</b>
c. FULL NAME OF (If NOT in hospital, give location) <b>Cardinal Glennon Memorial Hospital for Children</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>802 School</b>
3. NAME OF DECEASED (Type or print) <b>Jamie Marie Hornback</b>		4. DATE OF DEATH Month <b>September</b> Day <b>28</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>9-26-62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR: Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min. <b>2</b> IF UNDER 24 HR: Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min. <b>2</b>
11. BIRTHPLACE (City and state or country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Charles E. Hornback</b>		13b. MOTHER'S MAIDEN NAME <b>Cora A. (Aldridge)</b>	
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) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles Hornback, Charleston, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyaline Membrane Disease</b> DUE TO (b) _____ DUE TO (c) <b>773.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)		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 _____ to <b>DOA 9/28/62</b> and last saw her/him alive on _____ Death occurred at <b>8 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Eugene Lewis Jr MD.</b>		22b. ADDRESS <b>Cardinal Glennon Hosp.</b>	
22c. DATE SIGNED <b>10/1/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10/1/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town, or county) <b>Charleston, Mo.</b>	
24. FUNERAL DIRECTOR <b>Nunnelee Funeral Home, Charleston, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 1 1962</b>	
26. REGISTRAR'S SIGNATURE <b>Boad Smith, M.D.</b>			

VS 300  
Rev. 4/59

1

3

4 1

5 0

6

7 1

8 1

9

10

11

12 55-0

13

55

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 \_\_\_\_\_

*Not Embalmed*  
*L. Meyer*  
\_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_  
\_\_\_\_\_  
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.