

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**66 0008284**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2212**

**FILED MAR 10 1966**

VS 300 Rev. 4/59	DATE AMENDED	
1		
2		224
3		2
4		0
5		1
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12		92-0
13		
91		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b DOA	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Morgue</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3830 Ohio</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>McCLELLAND</b> Last <b>HORN</b>			4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Monsanto Co.</b>	9. AGE (last birthday) <b>69</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Months Days Hours Min.
11a. BIRTHPLACE (City and state or country) <b>Bonne Terre, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>George M. Horn</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Horn</b>	
14. NAME OF HUSBAND OR WIFE <b>Margaret Horn</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>Yes</b>		17. INFORMANT Address <b>Mrs. Margaret Horn, 3830 Ohio, St. Louis</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>Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>Indefinite</b> <b>Indefinite</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Bronchial Asthma</b>			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.) <b>4201</b>	
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 <b>January 1960</b> to <b>March 1 1966</b> and last saw him alive on <b>February 19 1966</b> Death occurred at <b>12:08 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>Nicholas A. Young M.D.</b>		22b. ADDRESS <b>4307 S. Grand Blk</b>	22c. DATE SIGNED <b>March 2 1966</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-4-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Hoffmeister Colonial Mortuary 6454 Chippewa, St. Louis 9, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 2 1966</b>	26. REGISTRAR'S SIGNATURE <b>Loed Smith, M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Nicholas Young  
4307 S. Grand

**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 *Bill C. Benson*

Licensed Embalmer No. *1164*

P. O. Address *St Louis Mo*

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.