

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 13 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37935
Registrar's No. 9774

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County 1
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution 6 Days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County _____
(c) City or town St Louis 22
(If outside city or town limits, write "RURAL")
(d) Street No. 1230 A. 9th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Charles Van Horn 565
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November day 13,
year 1939 hour 2:00 minute A. M.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY 14 1857
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November
8, 1939 to November 13, 1939
that I last saw him alive on November 13, 1939
and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 6 Days - If less than one day _____ hr. _____ min.

Immediate cause of death Chronic Myocarditis
Due to _____
Due to _____

9. Birthplace (City, town, or county) PENN. (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation _____
11. Industry or business _____
12. Name EMMANUEL VAN HORN
13. Birthplace PENN. (City, town, or county) (State or foreign country)
14. Maiden name SARAH KELPE
15. Birthplace PENN. (City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER, FATHER
16. (a) Informant's own signature PUBLIC ADMINISTRATOR
(b) Address CITY OF ST LOUIS
17. (a) BURIAL (b) Date thereof 11-16-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MEMORIAL PARK
18. (a) Signature of funeral director ALBERT H. HOPPE
(b) Address 4700 WASHINGTON
19. (a) NOV 26 1939 (b) J. B. Budek
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Geo M. Pike (M. D. or other)
Address 1515 Lafayette 11/13/39 Date signed

Not embalmed CF

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

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 this body is not embalmed, above space should be left blank.