.S. No. 300
EV. 10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13157

FILED MAY 4 1953

BIRTH NO. _____ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 4009 Registrar's No. 32

1. PLACE OF DEATH
a. COUNTY: Andrew
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SAVANNAH
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Andrew
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SAVANNAH 0020 8
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Issac
b. (Middle): Benton
c. (Last): Vanhorn

4. DATE OF DEATH (Month) (Day) (Year): 4-28-53

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 2-11-1874
9. AGE (In years last birthday): 79
If under 1 year: Months: 2 Days: 11
If under 24 hrs.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BANK Cashier
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Andrew
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: JASON VANHORN
13b. MOTHER'S MAIDEN NAME: NANCY MITTER
14. NAME OF HUSBAND OR WIFE: JULIA VANHORN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 468-05-9188
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs. Julia Vanhorn Savannah mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Continuous

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 4500
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June *, 19*50*, to* 4-25 *, 19*53*, that I last saw the deceased alive on* 4-25 *, 19*53*, and that death occurred at* 6:30 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Walter P. Medley (Degree or title): MD
23b. ADDRESS: Savannah
23c. DATE SIGNED: 4-29-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4-30-1953
24c. NAME OF CEMETERY OR CREMATORY: SAVANNAH
24d. LOCATION (City, town, or county) (State): SAVANNAH MO

DATE REC'D BY LOCAL REG.: 4-30-53
REGISTRAR'S SIGNATURE: Lillian Page
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Breit Funeral Home Savannah MO

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 10 1959

MAY 6

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 .....
Student Embalmer

Signed E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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 this body is not embalmed, fact should be so stated above.