

TEXAS DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

4430 27

STATE OF TEXAS

CERTIFICATE OF DEATH

STATE FILE NO.

8657

1. PLACE OF DEATH a. COUNTY Tarrant		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Texas b. COUNTY Tarrant	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Ft Worth OR TOWN Ft Worth precinct no.)		c. CITY (If outside corporate limits, write RURAL and give precinct no.) Ft Worth	
d. FULL NAME OF HOSPITAL OR INSTITUTION All Saints Hospital		d. STREET ADDRESS (If rural, give location) 5120 Meadowbrook	
3. NAME OF DECEASED (Type or Print) a. (First) Annie b. (Middle) Laura c. (Last) Yates		4. DATE OF DEATH February 5th 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 12-2-1868
9. AGE YEARS 80 MONTHS 2 DAYS 3		9. AGE YEARS MONTHS DAYS # UNDER 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Texas		12. FATHER'S NAME W.H. Horn BIRTHPLACE Texas	
13. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)	
15. SOCIAL SECURITY NO. None		16. INFORMANT'S SIGNATURE <i>Wm G. G. ...</i>	
17. 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular ventilation. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Vascular disease with hypertension. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus	
18a. DATE OF OPERATION None		18b. MAJOR FINDINGS OF OPERATION None	
20a. ACCIDENT SUICIDE HOMICIDE (Specify) No		20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No injury	
20c. (CITY, TOWN, OR PRECINCT NO.)		20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) None	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. HOW DID INJURY OCCUR? None	
21. I hereby certify that I attended the deceased from 3-16-44 , 19 44 , to 2-5 , 19 49 , that I last saw the deceased alive on 2-4 , 19 49 , and that death occurred at 3:30 Am. , from the causes and on the date stated above.			
22a. SIGNATURE (Degree or title) <i>E. ...</i>		22b. ADDRESS 210 Medical Arts Bldg.	
22c. DATE SIGNED 2-7-49		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE Feb 7th 1949		23c. NAME OF CEMETERY OR CREMATORY Rosehill Burial Park	
23d. LOCATION (City, town, or county) (State) Ft Worth Tarrant Texas		24. FUNERAL DIRECTOR'S SIGNATURE <i>Louis C. Hattburg, Guardian Ltd & Co</i>	
25a. REGISTRAR'S FILE NO. 318		25b. DATE REC'D BY LOCAL REGISTRAR FEB 8 1949	
25c. REGISTRAR'S SIGNATURE <i>Jana Brifford</i>			

NOTE THE INFORMATION CALLED FOR ON THE REVERSE SIDE

