

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

21507
2643

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 002
 City Kansas City (No. St. Lukes Hospital) St. _____ Ward _____

File No. _____

Registered No. _____

2. FULL NAME

Frank H. Hockaday
 (a) Residence No. St. Lukes Hosp. St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Hockaday

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10 - 1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	71	10	3	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work 126 Danner 127 B
 (b) General nature of industry, business, or establishment in which employed (or employer) 111 B
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Otie Hockaday

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Aura Hart

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Virginia

14. INFORMANT W. G. Hockaday (Address) Pecculiar, Mo.

15. FILED 6/13/29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 13 1929

17. I HEREBY CERTIFY, That I attended deceased from May 12th 1929 to June 13th 1929 that I last saw him live on June 13th 1929, and that death occurred, on the date stated above, at 4:40 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Cholecystitis - Gall Stones
Acute Cholangitis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Pulmonary Infarct

(duration) _____ yrs. _____ mos. 25 ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH Pecculiar, Mo.

DID AN OPERATION PRECEDE DEATH? yes DATE OF May 12th

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical X-Ray - Labors

(Signed) H. P. Kasher, M. D.
6/13, 1929 (Address) K. P. Crowe

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pecculiar DATE OF BURIAL 6/13 1929

20. UNDERTAKER Rummerburger Bros. Co. ADDRESS Harrisonville

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

REMARKS RESERVED FOR PHYSICIAN

V. S. No. 2.

