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

Do not use this space.

13060

1. PLACE OF DEATH

County: Jasper — Registration District No.: 417

Township: — Primary Registration District No.: 3021

City: Webb City (No. ..... St. ..... Ward)

File No.: ..... Registered No.: 50

2. FULL NAME: George L. Hockersmith

(a) Residence. No. Jack Chenault St. Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Jennie M. Hockersmith

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 13, 1902

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	11	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY): Okla

PARENTS

10. NAME OF FATHER: John Hockersmith

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

12. MAIDEN NAME OF MOTHER: Addie Hopkins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Kansas

14. INFORMANT: John Hockersmith
(Address): Purcell Mo.

15. FILED 4/14, 1930 R. M. Stormont REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 11 1930

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to April 11, 1930, that I last saw h. alive on April 11, 1930, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septic cerebral meningitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY): Septic otitis media

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

18. WHERE WAS DISEASE CONTRACTED: Gave attention of first trouble

IF NOT AT PLACE OF DEATH: While in U. S. Navy

DID AN OPERATION PRECEDE DEATH? ..... DATE OF ..... No

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. F. Hoggard, M. D.

4/14, 1930 (Address) Webb City Mo.

*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	DATE OF BURIAL
Purcell Cem	4/14 1930
20. UNDERTAKER	**ADDRESS**
Webb City Und Co	Webb City

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD