

NOV 24 1930

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

Do not use this space.

32777

1. PLACE OF DEATH

County Jackson
Township Blue
City Independence

Registration District No. 398
Primary Registration District No. 5554

File No. _____
Registered No. 326
Ward) _____

2. FULL NAME

Kathryn A. Hoek

(a) Residence. No. 6142 Brookside 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 F. 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. C. Hoek

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 1 - 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
52 9 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 210
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Fallitan
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Wm. Peerie

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

12. MAIDEN NAME OF MOTHER Bessie Hubbard

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

14. INFORMANT W. C. Hoek
(Address) 6142 Brookside

15. FILED 10-26, 1930 J. Hoek
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/26/1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Spine fractured spine in thoracic & lumbar region (Auto accident)

CONTRIBUTORY (SECONDARY) Instant Paralysis of Breathing Centers (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Oliver, M. D.

10/26, 1930 (Address) Independence

*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 Int. Moriah DATE OF BURIAL 10/27 1930

20. UNDERTAKER W. W. Newcomer Sons ADDRESS K. C. Mo.

N. B.—Every individual, and every physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

State Dept. SPECIAL REASON should be held property Exact terms of the

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Blue
City (No. _____) _____

Registration District No. 398
Primary Registration District No. 5354

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Kathryn R. Cook

(a) Residence. No. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
- (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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14.

INFORMANT _____
(Address) _____

15.

FILED 12/8/30 F. L. Cook
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/25-1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Fractured spine in Cervical & Dorsal region
Auto accident driver
Car was found wrecked
on side of highway 1/2 m. east
of Independence, Mo. with
no witnesses to tell the
truth or apparently lost
control of collision
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19____ (Address) _____

*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 _____

20. UNDERTAKER _____ ADDRESS _____

N. B.—Each item of information supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in full terms so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTER A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1880

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