

REC'D MAY 18 1938

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

14616
Do not use this space.

1. PLACE OF DEATH *Greene Co*
 (a) County *Greene* Registration District No. *316*
 (b) Township *Springfield* Primary Registration District No. *2001* Registered No. *305*
 (c) City *Springfield* (d) Street No. *1411 N. Missouri* St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME *WILLIAM SNIDER HOKE* *30*
 (a) Residence, No. *1411 N. Missouri* St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Julia Hoke*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 8 - 1857*

7. AGE YEARS *80* MONTHS *8* Days *28* If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Plumber*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Plumbing shop*
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky Hoke*
 13. NAME *Wm Hoke*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER 15. MAIDEN NAME *Wm Snider*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *J. B. Hoke Springfield Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Washwood* DATE *April 8 38*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. H. Stagner Springfield Mo.*

20. FILED *Apr 17 1938* *John A. George* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4/6* 19*38*

22. I HEREBY CERTIFY, That I attended deceased from *9:29* 19*38*, to *4:16* 19*38*
 I last saw him alive on *4/6* 19*38* Death is said to have occurred on the date stated above, at *11:0* m.
 The principal cause of death and related causes of importance were as follows:
cerebral hemorrhage
paralysis of whole left side
 Date of onset _____

Other contributory causes of importance: *High B. C. of pressure*

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) *J. H. Stagner* M. D.
 (Address) *Springfield Mo*

GROSS OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important.

STATE OF ILLINOIS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

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,

3358; Warren D. Hoblett # 4005 by Mr. Max Shob

Registered Apprentice No. 117, working under my personal supervision.

Signed

J. B. Klingner

Licensed Embalmer No. 3358

P. O. Address

Springfield

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, above space should be left blank.