

NOV 1 1938

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

34574  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 355

(b) Township Way Primary Registration District No. 1002

(c) City Kansas City (d) Street No. 3918 College Registered No. 3910

(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 Adle. Robt Hokanson

(a) Residence, No. 3918 college St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 3-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 77 6 2

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as saw mill, bank, etc. Farmer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Henry Co Ill

FATHER

13. NAME Theo. Hokanson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

MOTHER

15. MAIDEN NAME Sophia Carlson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

17. INFORMANT (ADDRESS) Josephine Wouley 3918 college

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Severy Hall Oct 7 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bylar Funeral Home 756 E. mo

20. FILED Oct 7 1938 Dr. D. Cronin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 5 1938

22. I HEREBY CERTIFY, That I attended deceased from 29th day of Sept, 1938, to Oct 5th, 1938

I last saw him alive on Oct 5th, 1938. Death is said to have occurred on the date stated above, at 1.0 P.M.

The principal cause of death and related causes of importance were as follows:

Right hemiplegia from cerebral thrombosis complicated by lobar pneumonia

Date of onset 9-28

Other contributory causes of importance: chronic myocarditis of senility

Name of operation..... Date of.....

What test confirmed diagnosis? clinical (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? no

If so, specify.....

(Signed) Dr. E. G. Brown

(Address) 480 Independence ave

A. 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.

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**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, .....

....., or by .....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**