

REC'D AUG 7 1939

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

24749  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson / Registration District No. 399  
 (b) Township Ykan / Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. W. C. Gen Hosp Registered No. 2962 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Berniece Hoke (Berniece Hoke)  
 (a) Residence, No. 921 Forest 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 15, 1908

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>30</u>	<u>3</u>	<u>7</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None

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

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) Mo

FATHER

13. NAME A B Hoke

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

MOTHER

15. MAIDEN NAME Mattie Wagner

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

17. INFORMANT Record Clerk  
(ADDRESS) San H 1

18. BURIAL, CREMATION, OR REMOVAL PLACE Carey Maus DATE 7-24 1939

19. FUNERAL DIRECTOR (NAME) Edo Bros Funeral  
(ADDRESS) 1416 Main and 16th

20. FILED July 22, 1939 M. M. Crowe  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-22 1939

22. I HEREBY CERTIFY, That I attended deceased from 7-15 1939 to 7-22 1939  
 I last saw her alive on 7-22 1939 Death is said to have occurred on the date stated above, at Widow  
 The principal cause of death and related causes of importance were as follows:  
Post operative para- Date of onset  
lytic shock 1939

Other contributory causes of importance:  
Upper digestive, Salpingitis, Oophoritis (not Tubercular or Gonorr)  
Appendectomy, salpingectomy 7/18/39  
 Name of operation as op. for salpingomy Date of 7/18/39  
 What test confirmed diagnosis? W Was there an autopsy? W

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) P. H. De Marier M. D.  
 (Address) Supt. W. C. Gen Hosp KC Mo

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.

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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.**