

JAN 8 1940

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

43230  
Do not use this space.

1. PLACE OF DEATH

(a) County DeKalb Registration District No. 209 ✓  
 (b) Township Camden Primary Registration District No. 4158  
 (c) City Maysville (d) Street No. \_\_\_\_\_ 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 25/ Rebecca Jane Hockenberry

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*writes the word*) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 11 1850

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>89</u>	<u>3</u>	<u>16</u>	

OCCUPATION

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

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) St. Marys Ohio

FATHER

13. NAME Calvin Wilkins

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

MOTHER

15. MAIDEN NAME (unknown) Shepard

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

17. INFORMANT Mrs Arlo Pike (ADDRESS) Maysville Mo.

18. BURIAL, CREMATION, OR REMOVAL Winslow Cem. (DeKalb Co.) 12/29-39

19. FUNERAL DIRECTOR (NAME) U. G. Pilcher (ADDRESS) Maysville Mo.

20. FILED 1-7 1940 Ethel H. Bone Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 28 -39 1939

22. HEREBY CERTIFY, That I attended deceased from Dec 27, 1939, to Dec 27, 1939. I last saw him alive on Dec 27, 1939. Death is said to have occurred on the date stated above, at 5:30 p.m.

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

Carcinoma of nose and throat

Date of onset \_\_\_\_\_

Other contributory causes of importance: Erysipelas originating in cancer site

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

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. home

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) W. R. Reynolds (Address) Maysville 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 importa

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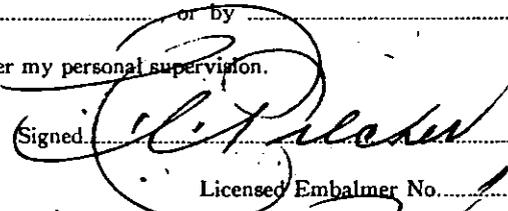
**STATEMENT BY LICENSED EMBALMER**

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. 1432

P. O. Address *Missouri*

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

43230  
Do not use this space.

1. PLACE OF DEATH  
 (a) County DeKalb Registration District No. 259  
 (b) Township..... Primary Registration District No. 4138 Registered No.....  
 (c) City Mayville (d) Street No..... 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 Rebecca Jane Hokenberry  
 (a) Residence, No.                      St.                       
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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.  
89 3 16

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

FATHER  
 13. NAME  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 27 1939

22. I HEREBY CERTIFY, That I attended deceased from 19... to... 19...  
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma of nose and throat  
(nose was primary Sept Feb 4, 40)  
 Other contributory causes of importance:  
Erysipelas Originating at Cervical site

Name of operation..... Date of.....  
 What test confirmed diagnosis? 57 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 R. R. Reynolds, M. D.  
 (Signed) Mayville Mo.  
 (Address)

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SHOULD STATE CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

