EB 22
U. S. No. 2
M—11-10-39
Rev. 5-17-39
I X21492
96

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 6 — 1940

Gr 5970

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8247

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 371

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Rural — St Ferdinand Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Bellefountaine & Chambers Roads
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 0/1/20
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Edward Hockensmith 252

3. (b) If veteran, name war None

3. (c) Social Security No. 330-18-8817

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eleanore Parke

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Oct. 30, 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 3 Days 21 If less than one day hr. min.

9. Birthplace (City, town, or county) Kentucky (State or foreign country) 1

10. Usual occupation Retired Shipping Sup't.

11. Industry or business National Lead Co.

FATHER
12. Name John Hockensmith 1
13. Birthplace (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Salina Ferguson
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Ruth Horsfalls
(b) Address 728 DeMun, Clayton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-40 (Month) (Day) (Year)
(c) Place: burial or cremation Antioch Cemetery

18. (a) Signature of funeral director Schrader Funeral Home
(b) Address Ballwin, Mo.

19. (a) FEB 22 1940 (Date received local registrar) (b) T R Meyer M D Dr PH (Registrar's signature) JC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 21, year 1940 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan. 5, 1940, to 2/21/, 1940 that I last saw him alive on 2/21/, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis	2 Yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

93 C

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) 1
Address 8321 N. Broadway Date signed 2/22/40

(Licensed Embalmer's Statement on Reverse Side)

Dr. Chappie 8321 N Bdy

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 Theo. Schrader

Licensed Embalmer No. 3066

P. O. Address Ballwin, Mo

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.