

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

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30663

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3420

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Several hours
(Specify whether years, months or days)
In this community Several hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4306 East-23 St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? U.S.A., 0 years.

3. (a) PRINT FULL NAME JOSEPHINE HOCKER

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Baby 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased 9 11 - 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 hr. 18 min.

9. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Baby

11. Industry or business Baby

12. Name A. R. Hocker

18. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Virginia Neshit

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. R. Hocker

(b) Address 4306 E. 23 St

17. (a) Burial (b) Date thereof 9/13/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Wash. Cemetery

18. (a) Signature of funeral director Wm. M. Crowe

(b) Address 9/13/41
(Date received local registrar) (Registrator's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 12
year 1941 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from SEPT. 11, 1941, to SEPT. 12, 1941
that I last saw her alive on SEPT. 11, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Premature 7mo

Due to unknown

Due to —

Other conditions —
(Include pregnancy within 3 months of death)

Major findings: Of operations —
Of autopsy —

Duration
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? —

While at work? (Specify type of place) (e) Means of injury —

23. Signature Wm. M. Crowe M. D. or other —
Address 39 Grand Date signed 9/12/41

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.