

FILED FEB 18 1944

Registration District No. **1000**

Primary Registration District No. **1000**

Registrar's No. **62**

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

1. PLACE OF DEATH:
 (a) County **Buchanan**
 (b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Methodist Hospt.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community.....
years, months or days)

3. (a) PRINT FULL NAME **James Joseph Bokay Jr.**
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **Single**

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

7. Birth date of deceased **Jan. 4, 1944**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	0	0	3 hr. 30 min.

9. Birthplace **St. Joseph Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business.....

12. Name **Sgt. James Joseph Bokay**

13. Birthplace **St. Joseph, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Dorothy Moresne Wilson**

15. Birthplace **Chetopa, Kansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. John E. Bokay**

(b) Address **R. R. # 6, St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **Jan. 7, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Morayn Cem.**

18. (a) Signature of funeral director **Clark Mortuary**

(b) Address **5025 King Hill Ave.**

19. (a) **1-7-44** (b) **Rose Herzog**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Buchanan**
 (c) City or town **St. Joseph, Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **Missouri Methodist Hospt.**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **5**
 year **1944** hour **12** minute **15** A.M.

21. I hereby certify that I attended the deceased from **Jan 4, 1944** to **Jan. 5, 1944**;
 that I last saw him alive on **Jan 5, 1944**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Androgynous formation of umbilical cord Vessels united to form cord far out on membranes rather than on placenta. With rupture of membranes one umbilical vein was severed with resulting loss of blood to baby.**

Other conditions (Include pregnancy within 3 months of death)
Stillborn cause of death - Anoxia

Major findings:
 Of operations.....
 Of autopsy..... **1602**

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: **R. P. Secor M.D.** (M. D. or other)
 Address **St. Joseph, Mo.** Date signed **1-6-44**

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 1/5/44

Registered Apprentice No.

working under my personal supervision.

Signed *Francis*

Licensed Embalmer No. 4238

P. O. Address St. Joseph, 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, fact should be so stated above.