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FILED FEB 9 1944

State File No. _____

Registration District No. _____

Primary Registration District No. 4068

Registrar's No. 29

1. PLACE OF DEATH:

(a) County CALLAWAY
(b) City or town MOKANE
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community home years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALLAWAY
(c) City or town MOKANE
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Delbert Hockemeyer

3. (b) If veteran, name war NO 3. (c) Social Security No. 192-09-1924

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife BERNARD FULTON 6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased SEPT. 18 1915
(Month) (Day) (Year)

8. AGE: Years 28 Months 4 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace STEEDMAN MO. O
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business _____

12. Name JOHN HOCKEMEYER
13. Birthplace MILLERSBURG MO. O
(City, town, or county) (State or foreign country)
14. Maiden name MARIE O'NEAL
15. Birthplace GASCONADE CO. MO. O
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. JAMES HOCKEMEYER
(b) Address MOKANE, MO

17. (a) BURIAL (b) Date thereof 1/24/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOKANE

18. (a) Signature of funeral director Glen Y. Manpin

(b) Address 712 Court Fulton, Mo.

19. (a) 1-24-1944 (b) Joce Moseutshoff
(Date received local registry) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. 23 day 23rd year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from March 26th 1943 to Jan. 23rd 1944 that I last saw him alive on Jan. 23 1944 and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage
diathesis Duration 1 yr.

Due to pneumonia 3-1943

Due to Acute Arthritis 1942

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

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? _____

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

23. Signature W. J. Williams (M. D. or other) _____

Address Mokane, Mo. Date signed 1/24/44

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

MOTHER FATHER

1967 OCT 1

MISSOURI DEPARTMENT OF HEALTH

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.

1967 OCT 1

Signed *Glen J. Marpin*

Licensed Embalmer No. *2725*

P. O. Address *Fulton, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 47

Primary Registration District No. 4068

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Mokane
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James D. Hockemeyer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 23 Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Sept. 18 (Month) (Day) (Year)

8. AGE: Years 28 Months _____ Days _____ If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

Due to Lobar Pneumonia 3/26/1944
(recovered)

Due to _____

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

Major findings: 108
Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature W.H. Williamson (M. D. or other) M.D.
Address Mokane, Mo. Date signed 1/24/1949

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

MOTHER FATHER

SUPPLEMENTAL

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

2296