. S. No. 2
M—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

5602

FILED MAR 14 1945

State File No.

Registration District No. 42 Primary Registration District No. 1600 Registrar's No. 189

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: State Hospital No. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 yrs. 11 mos. 24 days (Specify whether years, months or days)

In this community 15 years 11 months 24 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 48 (If outside city or town limits, write "RURAL")

(d) Street No. 140 S. Belmont St. 3 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charles F. Mock.

3. (b) If veteran, name war ✓

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of ~~husband or~~ wife Mrs. Chas. F. Mock

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

7. Birth date of deceased — (Month) — (Day) 1893? (Year)

8. AGE: Years 52? Months — Days — If less than one day hr. min.

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

10. Usual occupation Express hauler.

11. Industry or business Express.

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

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

16. (a) Informant Mrs. Chas. F. Mock

(b) Address 140 S. Belmont St. K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20 1945 (Month) (Day) (Year)

(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director C. B. Sedgefield

(b) Address 600 S 10th St

19. (a) 2-20-45 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 17 year 1945 hour 4 minute 51 A.M.

21. I hereby certify that I attended the deceased from 6-1-1944 to 2-16-1945 that I last saw him alive on 2-16-1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Toxemia	6 days.
Due to Fibrinous pleurisy and empyema.	9 days
Due to	
Other conditions Tabo-paresis (Include pregnancy within 3 months of death)	28 years.

Major findings:
Of operations 3 D
Of autopsy Fibrinous pleurisy of left lung with empyema.

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 J. H. Morrowey (M. D. ~~or other~~)

Address State Hospital No. 2 Date signed 2-17-45.

1377

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.