

Registration District No. **749** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:  
(a) County **JACKSON**  
(b) City or town **KANSAS CITY**  
(c) Name of hospital or institution:  
**1262 STRATFORD ROAD 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 **LIFETIME** (years, months or days)

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. **1262 STRATFORD ROAD**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **HELEN SHERIDAN HOKANSON**  
3. (b) If veteran, name war **NO**  
3. (c) Social Security No. **NONE**  
4. Sex **FEMALE** 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: **DECEMBER 5 1944**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **MARCH** day **2**  
year **1945** hour **2** minute **A** M.  
21. I hereby certify that I attended the deceased from **Jan 1st**  
**1945** to **March 2 1945**  
that I last saw her alive on **Feb 1st** **1945**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**2 25** hr. min.  
9. Birthplace **KANSAS CITY MISSOURI**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **INFANT**

Immediate cause of death  
**Sudden Death - Only found Dead in Bed 4 or 5 hrs**  
Due to **acute Death - Acute Pulmonary Congestion**  
Due to **Hypertrophy of Thyroid gland**  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: **64**  
Of operations \_\_\_\_\_  
Of autopsy **as above**

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name **EDWARD W. HOKANSON**  
13. Birthplace **SPOKANE WASHINGTON**  
(City, town, or county) (State or foreign country)  
14. Maiden name **HELEN E. FAUBIEN**  
15. Birthplace **KANSAS CITY MISSOURI**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **Mrs. Edward W. Hokanson**  
(b) Address **1262 Stratford Road**  
17. (a) **Burial** (b) Date thereof **Mar 3 1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Cemetery**  
18. (a) Signature of funeral director **D.W. Newsome Sons**  
(b) Address **1401 Brush Creek**  
19. (a) **Mar 2 1945** (b) **E. Brown**  
(Date received local registrar) (Registrar's signature)

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 **William W. ...** M.D. or other  
Address **233 Royal ...** signed **March 2 1945**

**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

*Amile M. Calhoun*

Licensed Embalmer No. 3506

P. O. Address KC 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.**