

No. 2
5-42
17-39
X32873

FILED NOV 6 1945

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard Co.

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

(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 All of Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town: Rural
(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 Jessie B. Hockett

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 22
year 1945 hour _____ minute P M.

21. I hereby certify that I attended the deceased from 9/22 to 9/22, 1945
that I last saw him alive on 9/22 and that death occurred on the date and hour stated above.

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

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

7. Birth date of deceased March 7, 1944
(Month) (Day) (Year)

Immediate cause of death Colic

8. AGE: Years Months Days If less than one day
1 - 6 - 16 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Lenard Hockett

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

14. Maiden name Fanny Wake

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

16. (a) Informant Father

(b) Address Stoddard Co.

17. (a) Rural (b) Date thereof Sept 23, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Cemetery

18. (a) Signature of funeral director Phyllis Taylor

(b) Address Director

19. (a) Oct 22, 45 (b) Stora Leone
(Date received local registrar) (Registrar's Signature)

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy 11/90

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 Orsaino (M.D. or other) _____
Address Stora Leone Date signed _____

1129

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

RECEIVED

District Health Office No. 2,

District File Number 1045-3152

Date Filed 10-31-45

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 W. C. Boy

Licensed Embalmer No. 4399

P. O. Address Poplar Bluff

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.