

FILED FEB 11 1948
149

Registration District No. _____ Primary Registration District No. **1002**

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

48
3
8

1030

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City**

(c) Name of hospital or institution **St. Luke Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 day**
(Specify whether)

In this community **23 yrs**
years, months or days

3. (a) PRINT FULL NAME **Milton R. Hoberecht**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **None**

4. Sex **M**

5. Color or race **W**

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

6. (b) Name of husband or wife **Marguerite Hoberecht**

6. (c) Age of husband or wife if live **42 years**

7. Birth date of deceased: **Jan - 20 - 1900**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
46	0	10	hr. _____ min. _____

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

10. Usual occupation **Training Officer Personnel**

11. Industry or business **Farm Credit Adm.**

MOTHER FATHER

12. Name **Charles Hoberecht**

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

14. Maiden name **Kelly Beck**

15. Birthplace **Greentridge Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Marguerite Hoberecht**

(b) Address **Leis Summit Mo**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **2-2-46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Columbia Mo**

18. (a) Signature of funeral director **M.B. Langford**

(b) Address **Leis Summit Mo**

19. (a) **2-2-46** (Date received local registrar)

(b) **Staldine Holmes** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**

(c) City or town **Leis Summit**
(If outside city or town limits, write "RURAL")

(d) Street No. **706 So Douglas**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **30**
year **1946** hour **06:00 PM** minute **00** M.

21. I hereby certify that I attended the deceased from **24 Dec 1945** to **30 January 1946**
that I last saw him alive on **30 January 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **myelogenous leukemia**
& Right sided Heart failure.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **740**

Major findings:
Of operations: _____

Of autopsy **Splenomegaly & Hepatomegaly**
& Right Ventricular Dilatation

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? _____

23. Signature **Cliff Miller MD**
Address **Leis Summit Mo** Date signed **1-31-46**

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 8 1964

FEB 23 1946

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

N. B. Langford

Licensed Embalmer No.

3833

P. O. Address

Feis Summit Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.