

FILED APR 10 1946

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 287

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 28 yr. 6 mo. 17 days  
(Specify whether days)

In this community 28 yrs. 6 mo. 17 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

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

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES HÖCKWORTH

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 2/5. Color or race negro

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

6. (b) Name of husband or wife Buchanan

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

7. Birth date of deceased 9-17-1881  
(Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 21  
If less than one day hr. min.

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

10. Usual occupation Common laborer

11. Industry or business Common labor

12. Name James Hockworth

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

14. Maiden name Mary Walter

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

16. (a) Informant Mrs. Anna Bailey

(b) Address 1620 Euclid Ave. P.O. No. 1

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3 7 45  
(Month) (Day) (Year)

(c) Place: burial or cremation Hannibal Mo.

18. (a) Signature of funeral director Walter Ross

(b) Address 1729 1/2 Ave

19. (a) Mar. 7, 1946 (Date received local registrar) (b) F. J. Maltrich (Registrar's signature) By R.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 6  
year 1946 hour 11 minute 35 A.M.

21. I hereby certify that I attended the deceased from 3-1- 1946 to 3-6- 1946  
that I last saw him alive on 3-6- 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis Duration 5 days

Due to Pneumonia 3 weeks

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 932

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 (D)

23. Signature J. H. Morsaw (M. D. or other) Address State Hosp. #2 St. Joseph Date signed 3-6-46

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

MOTHER FATHER

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

*Laurence A. Jones*

Registered Apprentice No. *378*

working under my personal supervision

Signed

*J. J. Maulone*

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.