S. No. 2
M—2-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 9 1948

Registration District No. 42

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 246

Primary Registration District No. 1000

Registrar's No. 128

1. PLACE OF DEATH:

(a) County: Buchannan

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

(c) Name of hospital or institution: 2018 Francis St.
Rosary Hill Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 75 days (Specify whether years, months or days)

In this community: 75 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Kansas (b) County: Doniphan

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

(d) Street No.: Elwood
(If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: Herman Kocrom

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

3. (c) Social Security No.: none

4. Sex: male

5. Color or race: white

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

6. (b) Name of husband or wife: May Kocrom

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

7. Birth date of deceased: July 9 1870 (Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 6 If less than one day hr. min.

9. Birthplace: Kansas City, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer - retired -

11. Industry or business: general

FATHER
12. Name: Karl Kocrom
13. Birthplace: ---- Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Christina Kruffhauf
15. Birthplace: ----- Germany (City, town, or county) (State or foreign country)

16. (a) Informant: R. H. Kocrom,
(b) Address: Troy, Kansas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-15-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Wathena, Kansas

18. (a) Signature of funeral director: [illegible]
(b) Address: 120 Tils Ave St Joseph, Mo.

19. (a) 2-3-48 (Date received local registrar) (b) E. E. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15 year 1948 hour 6 minute 30 a.m.

21. I hereby certify that I attended the deceased from Nov 1st, 1947, to Jan. 15th, 1948 that I last saw him alive on Jan. 14th, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Arterio-Sclerosis — Duration 4 yrs.

Due to:

Due to:

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

Major findings:
Of operations: None

Of autopsy: None

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: John L. Lucas (M. D. or other)

Address: Wathena, Kansas Date signed 1-16-1948

(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 A L Dodds

Licensed Embalmer No. Mo 3023

P. O. Address Wathena, Kansas

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.