

S. No. 2  
-12-45  
5-17-39  
1 X47070

**FREE MAY 20 1948**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **550**

**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: Duncan  
723 So. 11th St. (Nursing Home)  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 years  
(Specify whether years, months or days)

In this community Most of life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 723 South 11th Street  
(If rural, give location)

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

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

**3. (a) PRINT FULL NAME** ANNA HOCKER

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

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 October 17 1885  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>6</u>	<u>27</u>	____ hr. ____ min.

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

10. Usual occupation Housework

11. Industry or business Unknown

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Social Welfare Records

(b) Address 10th & Olive Sts., City

17. (a) Burial (b) Date thereof May 15, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director E. R. Deufalen

(b) Address 602 South 10th Street

19. (a) 5-17-48 (b) E. C. Jenkins  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 14  
year 1948 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from viewed  
May 14th, 1948, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency Duration

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

(c) Means of injury 3

23. Signature B. W. Tadlock Coroner (M. D. or other)

Address 1110 Hill Blvd Date signed 5/15/48

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

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 *Did not Embalm*  
*Mollie E. Sidenfaden Fox*

Licensed Embalmer No. *4235*

P. O. Address *St. Joseph, 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.