FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 13 1948

Registration District No. 93

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

22586

State File No.

Primary Registration District No. 5291

Registrar's No. 71

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Liberty R.R. III
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: I.O.O.F. Home 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether years, months or days)
In this community: 6 years & 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County:
(c) City or town: Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No.: Unknown
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: No

3. (a) PRINT FULL NAME: Nellie R Mock
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: W
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: None
6. (c) Age of husband or wife if alive: None years
7. Birth date of deceased: April (Month) 24 (Day) 1882 (Year)

8. AGE: Years 66 Months 2 Days 7 If less than one day hr. min.
9. Birthplace: Sullivan (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Retired Bookkeeper
11. Industry or business: Unknown
MOTHER FATHER
12. Name: Thomas M Mock
13. Birthplace: South Carolina (City, town, or county) (State or foreign country)
14. Maiden name: Rebecca Slater
15. Birthplace: Indiana (City, town, or county) (State or foreign country)
16. (a) Informant: J E Thomore
(b) Address: IOOF Home Liberty, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8/1/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Milan, Mo.
18. (a) Signature of funeral director: O. F. Gardner Jr.
(b) Address: Liberty, Mo.
19. (a) 7-31-1948 (Date received local registrar) (b) Minnie Haynes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1948 hour 12 minute 10 P.M.

21. I hereby certify that I attended the deceased from March 17, 1947, to July 31, 1948; that I last saw h. alive on July 30, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 days.
Due to: Hypertensive cerebro-vascular disease	10 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN
Underline the cause of 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: L. O. Schroeder (M. D. or other) M.D.
Address: Liberty, Mo. Date signed: 7/31/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number.....

Date Filed 8-12-48

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 O J Carder Jr

Licensed Embalmer No. 3934

P. O. Address Liberty, M

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.