No. 2
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X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 10 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28550

Registration District No. 3254 Primary Registration District No. 3072 Registrar's No. 181

1. PLACE OF DEATH

(a) County: Saline
(b) City or town: Marshall, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbons Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 12 Hrs (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Saline
(c) City or town: Marshall (If outside city or town limits, write "RURAL")
(d) Street No.: Fitzgibbon Hospital (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: John Hockaday Jr
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Male
5. Color or race: Col
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: Aug (Month) 19 (Day) 1948 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 11 hr. — min.

9. Birthplace: Marshall (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Child
11. Industry or business:

MOTHER FATHER

12. Name: John Hockaday
13. Birthplace: Frankfort (City, town, or county) Mo (State or foreign country)
14. Maiden name: Clara Mae Brown
15. Birthplace: Unknown (City, town, or county) Mo (State or foreign country)

16. (a) Informant: John Hockaday
(b) Address: Slater Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-20-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Slater Mo
18. (a) Signature of funeral director: Will Brno
(b) Address: Slater Mo
19. (a) Aug 24-1948 (Date received local registrar) (b) Sidney T. Gray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 20 year 1948 hour 12 minute 15 A.M.
21. I hereby certify that I attended the deceased from Aug 19, 1948, to Aug 19, 1948 that I last saw him alive on Aug 19, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Eclampsia of mother — Duration: 4 wks
Due to:
Due to:
Other conditions: Prematurity (Include pregnancy within 3 months of death)

Major findings:
Of operations: No
Of autopsy: No

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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: [illegible] M.D. (M. D. or other)
Address: Marshall, Mo Date signed: 8-22-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 9-9-48

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 not embalmed, Registered Apprentice No., working under my personal supervision.

Signed Sam M. Hill

Licensed Embalmer No. 1292

P. O. Address Slater 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.