

FILED JUN 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18975

26

BIRTH NO. _____		REG. DIST. NO. <u>77</u>	PRIMARY REG. DIST. NO. <u>3016</u>	Registrar's No. <u>152</u>
1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Jefferson City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Guthrie Mo.</u>		
c. LENGTH OF STAY (If in this place) <u>1 day</u>		d. STREET ADDRESS (If rural, give location) <u>St. Mary's Hospital</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION				
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Wallace</u> c. (Last) <u>Hozick</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 16 - 49</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 1 - 1975</u>	9. AGE (In years last birthday) <u>74</u> <input type="checkbox"/> UNDER 1 YEAR Months <u>0</u> Days <u>15</u> <input type="checkbox"/> UNDER 24 HRS. Hours <u>0</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Guthrie Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>Robert Tom Hozick</u>		13b. MOTHER'S MAIDEN NAME <u>Louise F. Foster</u>		14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Tom Bogie Callaway Mo.</u> ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary heart disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Repetitive chest (obstructive) surgical shunt</u>		INTERVAL BETWEEN ONSET AND DEATH <u>153X</u> <u>few weeks before</u>
19a. DATE OF OPERATION <u>June 15 - 49</u>	19b. MAJOR FINDINGS OF OPERATION <u>Stomach cancer, metastatic, hepatic</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE _____ (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____		
22. I hereby certify that I attended the deceased from <u>June 16, 1949</u> , to <u>June 16, 1949</u> , that I last saw the deceased alive on <u>June 16, 1949</u> and that death occurred at <u>6:45 AM.</u> from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Charles W. Saylor M.D.</u>		23b. ADDRESS <u>Jefferson City Mo.</u>		23c. DATE SIGNED <u>June 16 - 1949</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>JUNE 19 - 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>TRV YORK</u>	24d. LOCATION (City, town, or county) (State) <u>3 mi. West, Guthrie Mo</u>	
DATE REC'D BY LOCAL REG. <u>June 17 - 49</u>	REGISTRAR'S SIGNATURE <u>R. P. Dorris M.D. M.S. M.P.</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Holt - Claypool Soc. New Blaine</u> ADDRESS _____		

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 21 1950

JUL 8 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed LeRoy Clayton

Signed _____
Student Embalmer

Licensed Embalmer No. 4412

P. O. Address New Blainfield Va

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.