

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40812

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1145

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

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>	c. LENGTH OF STAY (in this place) <u>11</u> <u>3</u> DAYS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>SPEED BAPTIST HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>1044 W. WALNUT</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u>	b. (Middle)	c. (Last) <u>HOFMOCKEL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 24, 1949</u>
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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>7 JUNE 1873</u>	9. AGE (in years last birthday) <u>76</u>	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Min.
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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>RETIRED FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>MICHAEL HOFMOCKEL</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>HERMAN HOFMOCKEL</u>	ADDRESS <u>SPEED MO.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>		<u>3 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Degenerative Heart Disease</u> DUE TO (c) _____		<u>10 mo</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>4 22 2</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year), (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 2-21-1879 to 12-24-1949 that I last saw the deceased alive on 23-23, 1949, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>12-24-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>12/24/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>TABOR CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>HAMBURG IOWA</u>
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DATE REC'D BY LOCAL REG. <u>12-27-49</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Speed Mo.</u>
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(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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Max Rhodes*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*4071*

P. O. Address \_\_\_\_\_

*Springfield*

**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.