

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9193**

BIRTH NO. _____ REG. DIST. NO. **75** PRIMARY REG. DIST. NO. **4139** Registrar's No. **18**

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

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY CLINTON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Turney		c. LENGTH OF STAY (in this place) 857-	c. CITY OR TOWN TURNERY
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) 0250	

3. NAME OF DECEASED (Type or Print) a. (First) EMMA b. (Middle) JANE c. (Last) HOCKENSMITH			4. DATE OF DEATH (Month) (Day) (Year) March 3-1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 16, 1863	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months 7 Days 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or as if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Issac Moore		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Elwin Hockensmith (Deed)		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, so, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Will Hockensmith ADDRESS Waverly Lane	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH
		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. Influenza		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 480x	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) m.	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 **2-19-1953**, to **March 3, 1953**, that I last saw the deceased alive on **2-21-1953** and that death occurred at **7:30 a.m.** from the causes and on the date stated above.

23a. SIGNATURE (Name or title) J. Longfield, M.D.	23b. ADDRESS Lathrap, Mo	23c. DATE SIGNED 3/4/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-5-53	24c. NAME OF CEMETERY OR CREMATORY Osborn Cemetery	24d. LOCATION (City, town, or county) (State) Osborn Mo
DATE REC'D BY LOCAL REG. 3-9-53	REGISTRAR'S SIGNATURE Wm. Fred W. Moser	3907	25. FUNERAL DIRECTOR'S SIGNATURE DeSman Frank Cameron ADDRESS Mo

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..

Student.....
Signature of Student Embalmer

Signed *Harold L. Walker*

Licensed Embalmer No. *458*

P. O. Address *Lathrop, Or*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.