

0.300
0.48

FILED AUG 3 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24514
State File No.

BIRTH NO. _____		REG. DIST. NO. <u>133</u>		PRIMARY REG. DIST. NO. <u>3022</u>		Registrar's No. <u>76</u>	
1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Bethany</u>		c. LENGTH OF STAY (in this place) <u>2 mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Adams twp</u>		0410	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Reid Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Blue Ridge Community</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>			b. (Middle) <u>Esther</u>		c. (Last) <u>Hockridge</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7-27-53</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>8-4-1866</u>	
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months <u>11</u>		IF UNDER 24 HRS. Days <u>23</u>		Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Harrison County Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>George Ellwell</u>			13b. MOTHER'S MAIDEN NAME <u>Phyllis Jane Mamille</u>		14. NAME OF HUSBAND OR WIFE <u>William H. Hockridge</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Glenn Hockridge</u>			
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>Hypostatic Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture Left Hip</u>					6-2-53
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>E9030</u> <u>20</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Adams Twp. Harrison Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>6-2-53 10 am</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall on rug</u>			
22. I hereby certify that I attended the deceased from <u>6-2</u> , 19 <u>53</u> , to <u>7-27</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7-27</u> , 19 <u>53</u> , and that death occurred at <u>6:45 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Lieutenant H. Thayer DO</u>				23b. ADDRESS <u>Bethany Mo</u>		23c. DATE SIGNED <u>8-1-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-29-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		24d. LOCATION (City, town, or county) (State) <u>Bethany Mo</u>	
DATE REC'D BY LOCAL REG. <u>8-1/53</u>		REGISTRAR'S SIGNATURE <u>Zola Burris</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Haas</u>		
					ADDRESS <u>Bethany Mo.</u>		

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

(Licensed Embalmer's Statement on Reverse Side)

12-1-13
EP

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
Student Embalmer

Signed M. B. Jones

Licensed Embalmer No. 3899

P. O. Address Bithany 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.