

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **35918**
4868

FILED **OCT 28 1953**

REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 18 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		3048 0
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeside Hospital			d. STREET ADDRESS (If rural, give location) 601 4033 Tracy		
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) W.	c. (Last) Hoss	4. DATE OF DEATH (Month) (Day) (Year) 10 8 53	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-29-1879	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optician	10b. KIND OF BUSINESS OR INDUSTRY H.L.Meyer Co.	11. BIRTHPLACE (City and State or Foreign Country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Henry Hoss		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mary E. Hoss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 486-05-3288	17. INFORMANT'S SIGNATURE OR NAME ADDRESS H.C.Hoss 4033 Tracy KCMO.			
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.	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis DUE TO (c) Pneumonia				4221
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Atherosclerosis, cerebral apoplexy				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1952 to September, 1953 that I last saw the deceased alive on Oct 8, 1953 , and that death occurred at 11:30 m., from the causes and on the date stated above.					
23a. SIGNATURE James E. Griffin		23b. ADDRESS 3900 Falls		23c. DATE SIGNED 10/9/53	
24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 10-10-53	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	24d. LOCATION (City, town, or county) (State) Kansas City MO		
DATE REC'D BY LOCAL REG. 10-10-53	REGISTRAR'S SIGNATURE Seraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilley-Eylar KCMO.		

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

Melvin Dartea

Licensed Embalmer No. _____

4903

P. O. Address _____

J. C. M.

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.