

16002

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

2273

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>2273</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>			
b. CITY OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>25 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3532 Baltimore</u>				e. STREET ADDRESS (If rural, give location) <u>12 1622 Oakley 2228</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mac</u> b. (Middle) <u>G</u> c. (Last) <u>HOCKAYD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5 18 1954</u>				
5. SEX <u>1</u> <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 2</u>		8. DATE OF BIRTH <u>5-9-81</u>	
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Jacob T Kresse</u>			13b. MOTHER'S MAIDEN NAME <u>Carolina Greenwood</u>		14. NAME OF HUSBAND OR WIFE <u>William H. Hockayd</u>		
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 ADDRESS <u>Mrs Bertha Collins 3532 Baltm</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>Coronary occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Chronic sinus brain syndrome</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Compression change of 12th rib, 11th thoracic vertebrae 5 years.</u>					-INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>2 years.</u> <u>1 year.</u> <u>5 years.</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 1953</u> , to <u>May 18 1954</u> , that I last saw the deceased alive on <u>May 8 1954</u> , and that death occurred at <u>1:45 A. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>R. H. Boyd Jr.</u> (Degree or title) <u>DO 2</u>				23b. ADDRESS <u>9529 Sumner Rd Independence Mo.</u>		23c. DATE SIGNED <u>5/19/54</u>	
24a. BURIAL CREMATION (REMOVAL) (Specify) <u>Burial</u>		24b. DATE <u>5-20-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lee Summit</u>		24d. LOCATION (City, town, or county) (State) <u>Lee Summit Mo.</u>	
DATE REC'D BY LOCAL REG. <u>5-20-54</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John P. Shind - K-C-Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....
John P. Shurt

Licensed Embalmer No. 36

P. O. Address.....
N.C. 166

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.