

40794

FILED DEC 19 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 5171 Registrar's No. 331

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Aubert Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>St. Aubert Twp. 0140</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>			Length of stay in lb <u>27 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>RFD Mokane Mo</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Ella</u> Last <u>Hockemeyer</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1956</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1891</u>		9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</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>at home</u>		11. BIRTHPLACE (City and state or country) <u>Gasconade County Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>W. H. O'Neal</u>						14. MOTHER'S MAIDEN NAME <u>Eliabeth Stambaugh</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 <u>William Hockemeyer</u> Address: <u>Fulton Mo.</u>							
18. CAUSE OF DEATH - [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Senescent Melancholia</u> DUE TO (c) <u>Cystitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>30 years</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour <u>    </u> Month <u>    </u> Day <u>    </u> Year <u>    </u> a. m. <u>    </u> p. m. <u>    </u>													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE		
21. I attended the deceased from <u>12-10-56</u> to <u>12-14-56</u> and last saw her/him alive on <u>12-11-56</u> . Death occurred at <u>1:15 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>W. H. Payne M.D.</u>						22b. ADDRESS <u>R 43<sup>rd</sup> Fulton Mo</u>			22c. DATE SIGNED <u>12-15-56</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/16/56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mokane</u>			23d. LOCATION (City, town, or county) (State) <u>Mokane Missouri.</u>						
24. FUNERAL DIRECTOR <u>Murphy</u> ADDRESS <u>Fulton Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Dec. 15-1956</u>		26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>							

(Licensed Embalmer's Statement on Reverse Side)

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diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
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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.....  
*J. J. Ross*

Licensed Embalmer No. *735*

P. O. Address *Amherst*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.