

Health,  
& Welfare  
Public  
Service

FILED APR 28 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013313  
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 417

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> <i>0117</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>828 So. 10th St.</b>		Length of stay in 1b <b>Most Life</b>	d. STREET ADDRESS (If outside, give location) <b>828 So. 10th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>JACKSON</b> Last <b>HOCKADAY</b>			4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1906</b>	9. AGE (In years last birthday) <b>52</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY COUNTY</b>	11. BIRTHPLACE (City and state or country) <b>Wathena Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
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13a. FATHER'S NAME <b>Perry Hockaday</b>	13b. MOTHER'S MAIDEN NAME <b>Minnie Pattig</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Ruth Hockaday</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW #2</b>	16. SOCIAL SECURITY NO. <b>500-10-4163</b>	17. INFORMANT <b>Mrs. Homer Pasley</b> Address <b>St. Joseph, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 _____ Month, Day, Year a.m. _____ p.m. _____	

20d. INJURY OCCURRED WHILE AT <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 <b>St. Joseph</b>	COUNTY <b>Buchanan</b>	STATE <b>Missouri</b>
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21. I attended the deceased from **UNATTENDED** to \_\_\_\_\_ and last saw ~~him~~ <sup>her</sup> alive on \_\_\_\_\_  
Death occurred at **Not known** \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Louise H. Baker, M.D.</b>	22b. ADDRESS <b>302 Farm St. Joseph</b>	22c. DATE SIGNED <b>4-18-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-19-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Joseph</b>	(State) <b>Missouri</b>
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24. FUNERAL DIRECTOR <b>Stoney Funeral Home</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>April 18, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Handell</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secondary causes must wear use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be causally related.

APR 30 1958

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 *Charles E. Bennett* .....

Licensed Embalmer No. *4674* .....

P. O. Address: *St. Joseph* .....

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.