

pt. Health,
, & Welfare
S. Public
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022453
STATE FILE NUMBER

JUL 8 1958 Registration District No. 178 Primary Registration District No. 4281 Registrar's No. 41

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY Lewis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lewis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Canton	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Canton	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION At home	Length of stay in 1b 5 yrs.	d. STREET ADDRESS (If outside, give location) Rural route #2	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Addie Middle Ethel Last Hocker	4. DATE OF DEATH Month July Day 1 Year 1958
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1886	9. AGE (In years last birthday) 72	10. UNDER 1 YEAR Months 0 Days 0	11. UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Elk Garden, W. Va. /	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Strauss	13b. MOTHER'S MAIDEN NAME Louise Buskey	14. NAME OF HUSBAND OR WIFE Oliver M. Hocker
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 498-40-1123	17. INFORMANT Oliver M. Hocker, Canton, Mo.
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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) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 10 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	Unknown
	DUE TO (c) 4200	
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.)
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20c. TIME OF INJURY Hour 11:30 Month, Day, Year Jan 23, 1958 a.m. 11:30 p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION Canton	COUNTY Mo.	STATE
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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 Canton	COUNTY Mo.	STATE
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21. I attended the deceased from Apr 30, 1954 to Jan 23, 1958 and last saw her alive on Jan 23, 1958 Death occurred at 115 H.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Dr. Sam H. Roberts, D.O.	(Degree or title)	22b. ADDRESS Canton, Mo.	22c. DATE SIGNED 7-2-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 4, 1958	23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery	23d. LOCATION (City, town, or county) (State) Falls City, Richardson Co. Nebraska
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24. FUNERAL DIRECTOR Carl H. Bailey, Canton, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 7-2-58	26. REGISTRAR'S SIGNATURE P.W. Jennings, M.D.
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAR 11 1959

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 *Earl H. Buckley*

Licensed Embalmer No. *3615*

P. O. Address *Concord, Ma*

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.