Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-036972
STATE FILE NUMBER

FILED NOV 13 1958 Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 85

1. PLACE OF DEATH
a. COUNTY Lafayette
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Lexington Memorial Hospital — Length of stay in lb 3 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lafayette
c. CITY OR TOWN Mayveiw 0540 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS S. E. Corner (If outside, give location) (No street address) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First David Middle Thomas Last Hockensmith Sr.
4. DATE OF DEATH Month Day Year October 19, 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH March 29, 1890
9. AGE (In years last birthday) 68 — 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) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and state or country) Berlin, Missouri.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Louis J. Hockensmith
13b. MOTHER'S MAIDEN NAME Anna E. Carter
14. NAME OF HUSBAND OR WIFE Alma M. Schwab

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. none
17. INFORMANT Alma M. Hockensmith, Address Mayveiw, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 1st attack 10/15/58
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Malignant hypertension - 445X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 10/15/58, to 10/19/58 and last saw her/him alive on 10/19/58
Death occurred at 7:00 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Ben H Brasher MD
22b. ADDRESS Lexington, Mo.
22c. DATE SIGNED 10/29/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE October 22, 1958
23c. NAME OF CEMETERY OR CREMATORY Machpelah
23d. LOCATION (City, town, or county) (State) Lexington, Missouri

24. FUNERAL DIRECTOR Forrest F. Tempel ADDRESS Lexington, Missouri
25. DATE RECD. BY LOCAL REG. 11-8-58
26. REGISTRAR'S SIGNATURE Monena E Eastabrook

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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NOV 14 1968

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 [illegible]

Licensed Embalmer No. 2983

P. O. Address [illegible]

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.