

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3534 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>15 years</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osteopathic Hospital</u>		Side Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2505 Jackson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>CALVIN</u> Last <u>I Pock</u>			4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1960</u>			
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5. SEX <u>Male</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>6-15-1895</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Claddin Hotel</u>	11. BIRTHPLACE (City and state or country) <u>Seymour, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Joseph L. B. I Pock</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Jane Guberson</u>	14. NAME OF HUSBAND OR WIFE <u>Eula I Pock</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>549-05-4630</u>	17. INFORMANT Address <u>Mrs Eula I Pock - 2505 Jackson</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Peripheral Circulatory Collapse</u>		<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Uremia</u>	<u>30 days</u>
	DUE TO (c) <u>Chronic Glomerulonephritis</u>	<u>2 mon.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 <u>5:00</u> a.m. <u>0</u> p.m.	Month, Day, Year <u>July 6, 1960</u>
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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 <u>2333 Jackson, K.C. Mo.</u>	COUNTY <u>Mo.</u> STATE <u>Mo.</u>
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21. I attended the deceased from <u>May 10, 1960</u> to <u>July 6, 1960</u> and last saw her/him alive on <u>July 6, 1960</u> Death occurred at <u>July 6, 1960 5:00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Sherrill H. Fry</u>	22b. ADDRESS <u>2333 Jackson, K.C. Mo.</u>	22c. DATE SIGNED <u>7-7-60</u>
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23a. HOSPITAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 9, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St Joseph Missouri</u>
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24. FUNERAL DIRECTOR <u>Wilke Funeral Home</u> ADDRESS <u>2315 Penwood</u>	25. DATE RECD. BY LOCAL REG. <u>7-7-60</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
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DOCUMENT
BY AFFIDAVIT OF
Sherrill H. Fry MEDICAL CERTIFICATION

Dr. Stewart Emerson
815-1-1444
McNeill Stage
2333 Jackson
Rm 1-1411

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 *Chas E Wilks*

Licensed Embalmer No. *2644*
P. O. Address *Hemo*

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.