DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1115

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 100

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mercy Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Dead on arrival (Specify whether

In this community — years, months or days) 2 2 10

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

(c) City or town Higginsville Mo (If outside city or town limits, write "RURAL")

(d) Street No. 208 Hickox St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Bobby Jean Maycock

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Child

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Nov. (Month) 4 (Day) 1939 (Year)

8. AGE:	Years	Months	Days	If less than one day
—	—	2	4	— hr. — min.

9. Birthplace Higginsville Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Child 0

11. Industry or business —

FATHER
12. Name Louis Maycock. 0
13. Birthplace Cordier Mo. (City, town, or county) (State or foreign country) 0

MOTHER
14. Maiden name Ella Mae Jones
15. Birthplace Shelbina Mo (City, town, or county) — (State or foreign country)

16. (a) Informant's own signature Louis Maycock

(b) Address Higginsville Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/40 (Month) (Day) (Year)

(c) Place: burial or cremation Cordier Mo. City Cemetery

18. (a) Signature of funeral director Hadie Funeral Home

(b) Address Higginsville Mo.

19. (a) 1-8-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 8 year 40 hour 6:50 minute P M.

21. I hereby certify that I attended the deceased from Coroner, 19__; that I last saw h__ alive on __, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia (No Autopsy).	
Due to 1070	
Due to —	
Other conditions — (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy See above	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? — (e) Means of injury —

23. Signature [illegible] MD (M. D. or other)

Address R C Mo. Date signed 1/8/40

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X19511

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.