

No. 2  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31405**  
Registrar's No. \_\_\_\_\_

FILED OCT 13 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. **4383**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Madaway

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

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) i

(d) Length of stay: In hospital or institution \_\_\_\_\_

In this community 65 yrs 9 mo 18 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madaway <sup>74</sup>

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John W. Truman Hocken Hull

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30 year 1944 hour 11 minute 9 P.M.

21. I hereby certify that I attended the deceased from 9-26- 1944, to 9/30 1944

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Floza Hocken Hull 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Dec 12 1878  
(Month) (Day) (Year)

that I last saw him alive on 9/30 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to Nephritis ✓

8. AGE: Years 65 Months 9 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Produce Dealer

Major findings: Of operations \_\_\_\_\_

Of autopsy none

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joseph H Hocken Hull

13. Birthplace unknown <sup>GA</sup>  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown <sup>GA</sup>  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Floza Hocken Hull

(b) Address Graham Mo.

17. (a) BURIAL (b) Date thereof Oct 22 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Graham Mo

18. (a) Signature of funeral director W. G. Morgan

(b) Address Mount Airy Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature E. L. Morgan (M. D. or other) 0

Address Graham Mo Date signed 10/12/44

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**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 with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 31405

Registration District No. 253

Primary Registration District No. 4383

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County no charge  
 (b) City or town Thaddeus  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME

John W. Hockenbuhl

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced sn

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 12 (Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days \_\_\_\_\_ (less than one day) \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) no

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 30  
 year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to neuropathic chronic

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:

Of operations 131 lb

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature O. L. Morgan (M. D. or other) \_\_\_\_\_

Address Graham, Mo Date signed 10/19/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

