

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22204
Registrar's No. 773

FILED JUL 26 1948

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
In this community 6 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert Docker

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Martha Docker 6. (c) Age of husband or wife if alive years

7. Birth date of deceased About 1873
(Month) (Day) (Year)

8. AGE: Years 75 Months ? Days ? If less than one day hr. min.

9. Birthplace Newby, England
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name William Docker

13. Birthplace Unknown, England
(City, town, or county) (State or foreign country)

14. Maiden name Unknown Williams

15. Birthplace Unknown, England
(City, town, or county) (State or foreign country)

16. (a) Informant Perryman Funeral Home

(b) Address Red Oak, Iowa

17. (a) Removal (b) Date thereof July 18, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Evergreen Cemetery, Red Oak, Iowa

18. (a) Signature of funeral director Walter Meierhoff

(b) Address 1946 Colhoun St., St. Joseph, Mo.

19. (a) 7-20-48 (b) B. B. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Montgomery
(c) City or town Red Oak
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17th
year 1948 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 11, 1948 to July 17, 1948
that I last saw him alive on July 17, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration 12 hr.
Myocardial Insufficiency

Due to Had strangulated Pilonidal Cyst
approximately 15 days ago

Due to Septicemia and gangrene
and anastomosis. Exp. July 11, 1948

Other conditions Septicemia
(Include pregnancy within 3 months of death)

Major findings: As described above.
Of operations As described above.
Of autopsy As described above.

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

22. If death was due to external cause, 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 _____ (b) Means of injury _____

23. Signature Robert H. Conard (M. D. or other) MD
Address St. Joseph, Mo. Date signed 7/19/48

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

300
47
-39
3908

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..... *Albert C. Harrington*.....
Licensed Embalmer No. 3258 Missouri
P. O. Address St. Joseph, Mo.

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.