

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **43350**FILED DEC 22 1949
85330-49
BIRTH NO. _____ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **3071** Registrar's No. **57**

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater	
d. FULL NAME OF HOSPITAL OR INSTITUTION none		d. STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED (Type or Print) a. (First) Kenneth b. (Middle) Falls c. (Last) Falls		4. DATE OF DEATH (Month) (Day) (Year) Dec. 9-1949	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) baby	8. DATE OF BIRTH 12/6/1949
9. AGE (In years last birthday) 3		IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baby		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Slater, Mo.
12. CITIZEN OF WHAT COUNTRY? U S		13a. FATHER'S NAME Ralph Wright	
13b. MOTHER'S MAIDEN NAME Tina Falls		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ✓	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Herman Hockaday, Slater, Mo.		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Strangulation ANTECEDENT CAUSES DUE TO (b) Aspiration of emesis DUE TO (c) Prematurity II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 10-15 Min		9760X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 12-6 , 19 49 , to 12-9 , 19 49 , that I last saw the deceased alive on 12-9 , 19 49 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Walter H. Hockaday, M.D.		23b. ADDRESS Slater, Mo.	
23c. DATE SIGNED 12-9-49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 12-9-49		24c. NAME OF CEMETERY OR CREMATORY Nelson	
24d. LOCATION (City, town, or county) (State) Nelson, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Earl C. Held	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 12-12-49		ADDRESS Hill Brothers Slater Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED DEC 19

District Health Officer No. 8.

District File Number _____

Date Filed 12-21-49

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 _____

Body was not embalmed.

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed A. C. Hill

Licensed Embalmer No. 3090

P. O. Address State

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.