

S. No. 2
DM-542
5-17-39
X32873

22246

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 14 1943

Registration District No. 297

Primary Registration District No. 6021

Registrar's No. 4

1. PLACE OF DEATH:
 (a) County Ray
 (b) City or town Hope, Rural R.
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community most of his life (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Ray
 (c) City or town Hardin, Mo., P.O. #10
 (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 Homer Hoover
 (b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 8
 year 1943 hour 11 minute 9 A.M.
 21. I hereby certify that I attended the deceased from June 19
1943 to July 8 1943
 that I last saw him alive on July 8 1943
 and that death occurred on the date and hour stated above

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Serlie Rust 6. (c) Age of husband or wife if alive 65 years
 7. Birth date of deceased Feb 8 - 1876
 (Month) (Day) (Year)

Immediate cause of death Heart Blocky
Poor Voltage & Fibrillation Duration 3 weeks

8. AGE: Years 67 Months 5 Days 0
 If less than one day _____ hr. _____ min.

Due to Subacute Cystotomy 2 weeks

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

Due to Prostatic Glands
Enlarged and infected

10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death) 95a

11. Industry or business _____

Major findings: Of operations _____

12. Name Abraham Hoover

Of autopsy _____

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

14. Maiden name Susan Heavner

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

16. (a) Informant W. F. Warner

(b) Address Eschelon Springs

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9, 1943
 (Month) (Day) (Year)

(c) Place: burial or cremation New Hope

18. (a) Signature of funeral director Jno. W. H. Hirschfeld
 (b) Address Hardin, Mo.

19. (a) July 8, 43 (Date received local registrar) (b) Mrs. Shus. W. Shippard (Registrar's signature)

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 Marion Harms (M. D. or other) _____
 Address Hardin, Mo. Date signed 7/8/43

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

39
8
0

MOTHER FATHER

1280

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 7-13-48

FEB 15 1957

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 me
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed John W. Kripochild
Licensed Embalmer No. 2789
P. O. Address Hardin 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.