DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14155

State File No.

Registration District No. 16 | Primary Registration District No. 5020 | Registrar's No. 3

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

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town (Rural) Rochester Township
(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 3 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County ANDREW
(c) City or town COSBY, (RURAL)
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME JOHN HOOVER 160
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 Married
6. (b) Name of husband or wife Mollie
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased April 26 1880 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
59	11	9	hr. min.

9. Birthplace Andrew County (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name John Hoover
13. Birthplace Indiana (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Schildknecht
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Edwin C. Hoover
(b) Address Cosby Mo
17. (a) Union Star Mo. (Burial, cremation, or removal) (b) Date thereof April 7 1940 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director Lucile M. Wilson
(b) Address King City Mo
19. (a) 4-6-1940 (Date received local registrar) (b) Vernice A. Fite (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5TH year 1940 hour 4 minute 5 A.M.

21. I hereby certify that I attended the deceased from March 27, 1940, to April 5, 1940; that I last saw him alive on April 1, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death STARVATION	
Due to PARALYSIS OF THROAT	10 DAYS
Due to CEREBRAL HEMORRHAGE 13 YRS AGO.	
Other conditions INTERSTITIAL NEPHRITIS (Include pregnancy within 3 months of death)	

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

Major findings:
Of operations
Of autopsy

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 J. B. Riggs MD (M. D. or other)
Address Helena Mo Date signed 4/5/40

(Licensed Embalmer's Statement on Reverse Side)

RW

RECEIVED
District Health Officer No. 11,
District File Number 540-718
Date Filed MAY 9 1940

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 Lucile M Wilson

Licensed Embalmer No. 2830

P. O. Address King City 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, above space should be left blank.

o. 2B
2-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14155

Registration District No. 16 Primary Registration District No. 3020 Registrar's No.

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town Rochester T.P
(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
In this community (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME John Hoover
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 m
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 59 Months 11 Days 9 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 5 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Paralysis of throat [illegible] Duration
Due to Cerebral Hemorrhage 13 yrs ago
Due to Interstitial nephritis (Chronic)
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Jas. P. Riggs (M. D. or other)
Address Helena Mo Date signed

SUPPLEMENTARY