

S. No. 2  
5-1/47  
5-17-39

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31684**

Registered District No. **6/1947**

Primary Registration District No. **303**

Registrar's No. ....

53  
1  
2

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

1. PLACE OF DEATH:

(a) County Laclede Co

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

(c) Name of hospital or institution: Wallace Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 hrs.  
(Specify whether years, months or days)

In this community 11 months

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Laclede

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

(d) Street No. Richland Rt. 2  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME James Edward HOYLE

3. (b) If veteran, name war .....

3. (c) Social Security No. 510-07-7119

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Martha Holtgrave

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased June 12 1884  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>3</u>	<u>18</u>	hr. .... min.

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

10. Usual occupation Farmer

11. Industry or business .....

MOTHER: { 12. Name unknown

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 Mr. J. C. Hoyle

(b) Address Richland Rt. 2

17. (a) Burial (b) Date thereof 10/2/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Kansas

18. (a) Signature of funeral director Galmer

(b) Address Lebanon Mo.

19. (a) 10-4-1947 (b) Dr. Frank Heugel  
(Date received local registry) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 30  
year 1947 hour 2 minute 20 AM.

21. I hereby certify that I attended the deceased from 7-29-47  
....., 19..... to 9-30, 19.....  
that I last saw him alive on 9-30, 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Peritonitis

Due to ruptured appendix

Due to of operation

Other conditions Ruptured appendix  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:  
Of operations Generalized peritonitis

Of autopsy abdomen full of pus

Underline the cause of 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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

(e) Means of injury gun

23. Signature Dr. Heugel (M. D. or other) M.D.

Address Lebanon Mo. Date signed 9-30-47

Received 10/7/47  
Laclede County Health Unit  
File No. 9-47-166  
Date Filed 10/8/47

REC  
OCT 14 1947

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 S. R. Palmer  
Licensed Embalmer No. 2208  
P. O. Address Lebanon 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.