

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH

County

*Newton*

Township

*Dayton*

or Village

or

City

(NO.

Registration District No.

*673*

File No.

*#7333*

Primary Registration District No.

*5818*

Registered No.

*4*

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

*William Hoover*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

*Male*

*White*

*Single*

DATE OF BIRTH

*Jan 29 - 1911*  
(Month) (Day) (Year)

AGE

*11* yrs. *11* mos. *11* ds.  
IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

BIRTHPLACE

(City or town, State or foreign country)

*Newton Co, Mo*

NAME OF FATHER

*Wm. Hoover*

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

*Indiana*

MAIDEN NAME OF MOTHER

*Belle Wilson*

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

*Mo*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Wm. Campbell*

(ADDRESS)

*Seneca Mo*

Filed

*9-28, 1911*

*A. C. Hill*

REGISTRAR

DATE OF DEATH

*Feb. 9, 1911*  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

, 1911, to , 1911,

that I last saw h alive on , 1911,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*The child was dead when I first saw it - it had been dead 1 hour - likely had pneumonia, as I found others in family with*  
Contributory *pneumonia*

(Signed) *Wm. Campbell* M. D.  
*2/9* 1911 (Address) *Seneca Mo*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_ yrs. \_\_\_ mos. *11* ds. In the State \_\_\_ yrs. \_\_\_ mos. *11* ds.

Where was disease contracted If not at place of death? *Y*

Former or usual residence *A*

PLACE OF BURIAL OR REMOVAL *Country Cemetery* DATE OF BURIAL *2/10, 1911*

UNDERTAKER *Hennes* ADDRESS *Neosho Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

