

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH **43579**

PLACE OF DEATH
County Shelby Co.
Township Salt River
or
Village Shelbyville
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 830 File No. _____
Primary Registration District No. 6091 Registered No. 60

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

FULL NAME James Henry Hooper

PERSONAL AND STATISTICAL PARTICULARS
SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

MEDICAL CERTIFICATE OF DEATH
DATE OF DEATH Dec 11, 1916
(Month) (Day) (Year)

DATE OF BIRTH March 15, 1844
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 5, 1916, to Dec 10, 1916, that I last saw him alive on Dec 10, 1916, and that death occurred, on the date stated above, at 8 a. m.

AGE 72 yrs. 8 mos. 28 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Infectious by accompanying shock
1916
115 (Duration) yrs. mos. 6 ds.

OCCUPATION (a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Contributory congruence (SECONDARY) (Duration) yrs. mos. 2 ds.

BIRTHPLACE (City or town, State or foreign country) Bloomington Mo.

NAME OF FATHER Wm Hooper

BIRTHPLACE OF FATHER (City or town, State or foreign country) Myland

MAIDEN NAME OF MOTHER Rada Ann Snyder

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

(Sign) H. C. Vaughn M. D. (Address) Shelbyville Mo
State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) R. S. Hooper

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

(ADDRESS) Shelbyville Mo.

PLACE OF BURIAL OR REMOVAL Shelbyville Mo. 0007 DATE OF BURIAL Dec 12, 1916

Filed Dec 19, 1916 R. S. Battledy REGISTRAR

UNDERTAKER J. M. Thompson Son ADDRESS Shelbyville Mo.

PLACE OF DEATH

County.....
 Township.....
 or
 Village.....
 or
 City..... (NO.)

Registration District No.

File No.

Primary Registration District No.

Registered No.

St. 1844 Wood (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Specify the word)
DATE OF BIRTH	(Month)	(Day)
AGE yrs. mos. ds.	(Year)

OCCUPATION
 (a) Trade, profession, or particular kind of work
 General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
 (City or town, State or foreign country)

NAME OF FATHER
 BIRTHPLACE OF FATHER
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER
 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____

Filed _____ 191..... REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH:, 191..... (Month), 191..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from, 191....., to, 191.....
 that I last saw h..... alive on, 191....., and that death occurred, on the date stated above, at..... m.
 THE CAUSE OF DEATH was as follows:

..... (Duration) yrs. mos. ds.

Contributory (SECONDARY)

..... (Duration) yrs. mos. ds.

(Signed) 191..... (Address) M. D.

*State the Disease Causing Death, or, in deaths from Violent Cause, 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. ds. State..... yrs. mos. ds.
 Where was disease contracted if not at place of death?

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL, 191.....

UNDERTAKER

ADDRESS

Filed _____ 191..... REGISTRAR

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Shelby Registration District No. 830 File No. 43579
 Township Salt Run or Primary Registration District No. 6191 Registered No. 60
 Village or City (NO. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME James Henry Hooper

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

6 DATE OF BIRTH (Month) (Day) 1 (Year)

7 AGE yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)

15 Filed MC 13 1916 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191 (Year)

17 I HEREBY CERTIFY, that I attended deceased from that I last saw h. alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Fractured Leg
accident
Duration yrs. mos. ds. 6 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. 3 ds.

(Signed) MC 13 1916 (Address)

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191

20 UNDERTAKER ADDRESS

