

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

JAN 20 1927

37340  
File No. \_\_\_\_\_  
Registered No. 1268

1. PLACE OF DEATH  
County... Buchanan County... Registration District No. 85  
Township... \_\_\_\_\_ Primary Registration District No. 1001  
City... St. Joseph... (No. Mo., Med. Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Viola Estella Hoover  
(a) Residence. No. 803 North 2nd. St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female  
4. COLOR OR RACE White  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Thomas Hoover  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 3, 1889  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 37 4 19  
8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed (or employer) At Home  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Riverton  
(STATE OR COUNTRY) Nebraska

10. NAME OF FATHER Thomas Wilford  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY) England  
12. MAIDEN NAME OF MOTHER Margret Hasting  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Forest City  
(STATE OR COUNTRY) Missouri

14. Informant Thomas Hoover  
(Address) 803 North 2nd St.

15. Filed John G. White  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 22 1926  
17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1926, to Dec 22 1926, that I last saw h. alive on Dec 22 1926, and that death occurred, on the date stated above, at 12 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Valvular Heart Disease  
Contributory Suspected Turner (SECONDARY)  
(duration) 1 yrs 6 mos da.  
(duration) 5 yrs mos da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH?   
DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? No  
WHAT TEST COMPLETED DIAGNOSIS? *Cholesterol*  
(Signed) *Raymond J. Cook*, M. D.  
12/22/26 (Address) *Phys & Surg Med*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)  
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Mora  
DATE OF BURIAL Dec 23 1926

20. UNDERTAKER *Therman Farris*  
ADDRESS *1208 Francis*

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.

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumo $\dot{g}$ ia"); *Lobar pneumonia*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Buchanan Registration District No. 85 File No. \_\_\_\_\_  
 Township St. Joe Primary Registration District No. 1001 Registered No. 1268  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Diola Estella Hoover  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
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8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 22 19 26

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, (that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_)

THE CAUSE OF DEATH WAS AS FOLLOWS:  
chronic valvular heart disease

CONTRIBUTORY (SECONDARY) CAUSE infected tonsils (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
cause unknown (duration) 5 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH: \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS: \_\_\_\_\_  
 (Signed) Richard F. Cook, M. D.  
 , 19\_\_\_\_ (Address) Phil Hoover M.D.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

15. 18 1927 John G. W. REGISTRAR  
 FILED \_\_\_\_\_

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

N. B.—P. CAUSE J. REGISTRARS SHALL NOT RECEIVE A F OR CERTIFICATES UNTIL THEY ARE COMPLETE A. PRESCRIBED BY LAW  
 WHITE PRINT, WITH IMPRINTING THEREON—THIS IS A FERM. AGE should be stated EXACTLY. Exact statement of OCCUPATION. J. very important.

SUPPLEMENTARY

Q.S.

Cause of Infected Amies. Unknown.

S-37340