LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

3177-2 (2)

1. PLACE OF DEATH
County St. Clair — Registration District No. 1037 — File No.
Township — Primary Registration District No. 6013 — Registered No.
City Osceola (No. ..... St. ..... Ward)

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

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Molly Hooper

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 30 1850

7. AGE: YEARS 78 — MONTHS 6 — DAYS 13 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(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): Missouri

PARENTS
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Not Known
12. MAIDEN NAME OF MOTHER: Mary Ann Mayfield
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Tenn

14. INFORMANT: Jess Hooper
(Address): Osceola Mo.

15. FILED Jan 11 1930 L. Garrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4/14 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. ..... ds

CONTRIBUTORY (SECONDARY): Arterial Sclerosis
(duration) ..... yrs. ..... mos. ..... ds

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 74 A
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) O S Hull Coroner, M.D.
, 19 (Address) Osceola Mo

*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: Bear Creek Cem — DATE OF BURIAL: 4/15 1929

20. UNDERTAKER: O S Hull — ADDRESS: Osceola

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

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 COUNTY)

PARENTS

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)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased .....,19....., to .....
that I last saw h..... alive on.....
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....

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).....
, 19 (Address)

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

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

20. UNDERTAKER	ADDRESS