

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

Do not use this space.

5367

1. PLACE OF DEATH

County Audrain Registration District No. 24951 File No. _____
 Township William Wilson Primary Registration District No. 5037B Registered No. 2 ~~18~~
 City Thompson (No. _____) St. _____ Ward _____

2. FULL NAME

Thomas J. Hoyer

(a) Residence. No. R.F. 112 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

Farmer

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

May-25-1839

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>93</u>	<u>8</u>	<u>11</u>	

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)

Jump Town
Missouri

(STATE OR COUNTRY)

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

14. INFORMANT

D. W. McKelhan
(Address) D. Thompson and

15. FILED

Feb 6th 1929 Geo. S. Milligan
Feb. 23-1929 W. H. Light
REGISTRAR

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

Feb 6th 1929

17.

I HEREBY CERTIFY, That I attended deceased from _____, 1928, to Feb 6, 1929, and that (that I last saw h. _____ alive on Feb 6, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82 Paralysis

CONTRIBUTORY (SECONDARY)

Simultaneous

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) G. F. Dohson, M. D.
, 19 (Address) met 20 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

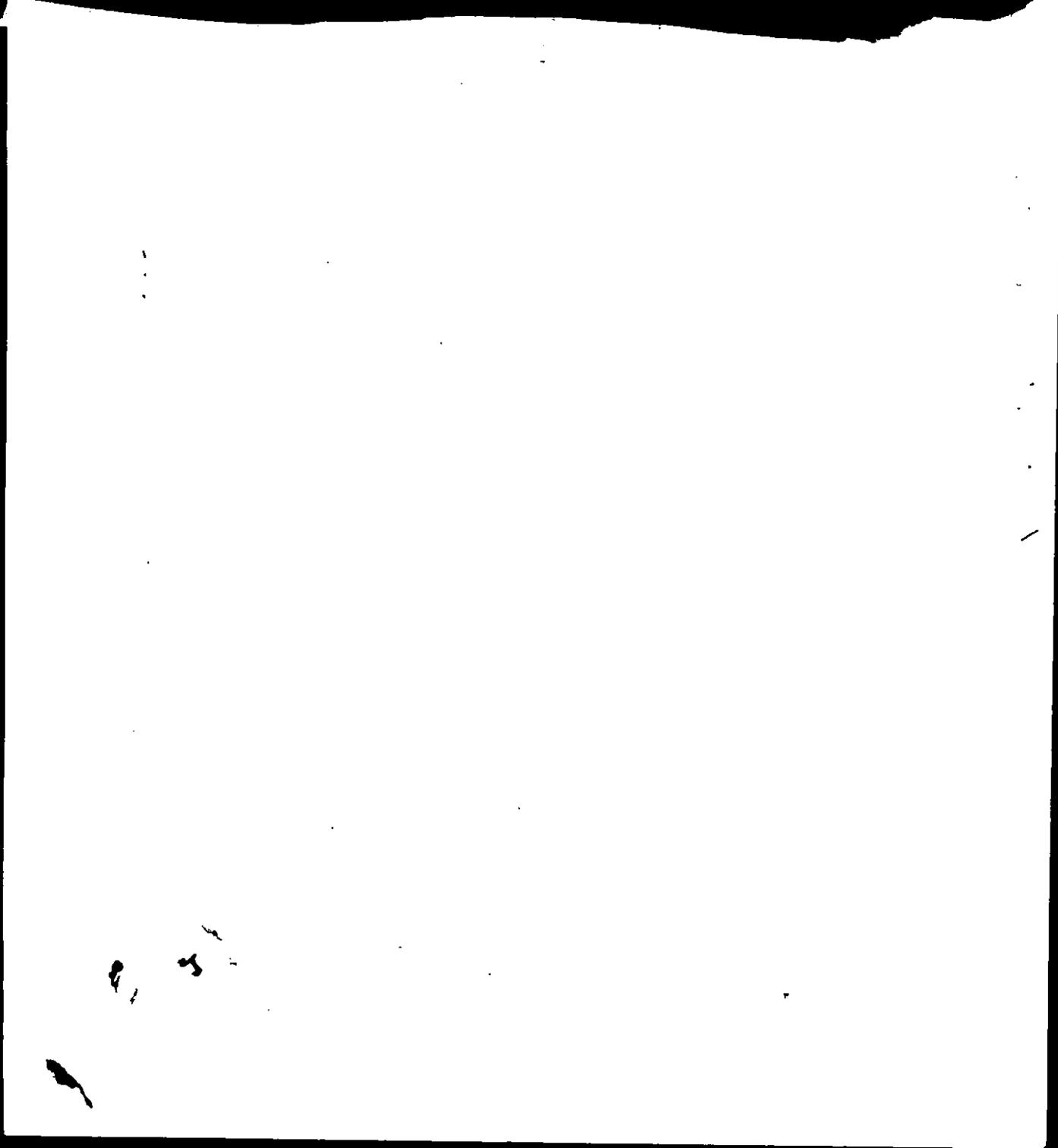
DATE OF BURIAL

Thompson and 2-7 1929

20. UNDERTAKER

ADDRESS

H. A. Pruitt Thompson and



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Audrain Registration District No. 951 File No.
 Township Wilson Primary Registration District No. 5037 B Registered No. 2
 City (No.) St. Ward

2. FULL NAME

Thomas J. 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. 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) wid

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 COUNTRY)

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 J. Tolson
 (Address) Mexico, Mo

15. FILED 5-6-29 M. Blythe
 1929

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 6 1929

17. I HEREBY CERTIFY That I attended deceased from 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:

Brain Cerebral Analysis

CONTRIBUTORY (SECONDARY)

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)....., M. D.

, 19 (Address)

*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.

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

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sign CAUSE OF DEATH in plain terms, so that it may be readily understood. Exact statement of OCCUPATION is very important. REGISTRARS 6. FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-5367