

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

Do not use this space.

36761-a

1. PLACE OF DEATH

County DeWitt
Township Current
City Cedar Grove (No.)

Registration District No. 1835
Primary Registration District No. 5271

File No.
Registered No. 4 St. Ward)

2. FULL NAME Doyle Hoodenpyle

(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 4 yrs. 1 mos. 14 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-11-1929
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
* 1 14

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) Cedar Grove
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Wphus Hoodenpyle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) DeWitt Co. Mo.
12. MAIDEN NAME OF MOTHER Charley Fraege
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) DeWitt Co. Mo.

14. INFORMANT mother
(Address) Cedar Grove

15. FILED 3, 1930 J.A. Kusack REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-25-1929

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:

never saw child until after death. think from history of case it was pneumonia 109A (duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY)

10/10 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? no DATE OF WAS THERE AN AUTOPSY? no WHAT TEST CONFIRMED DIAGNOSIS? none (Signed) S. H. Downing, M. D. 19 (Address) Salem - 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 Green Forest DATE OF BURIAL 11/26 1930

20. UNDERTAKER ADDRESS



**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 West
Township Current
City..... (No....., St....., Ward.....)

Registration District No. 1035
Primary Registration District No. 3371

File No.....
Registered No. 4

2. FULL NAME

Doyle Hoodenspyle

(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

MEDICAL CERTIFICATE OF DEATH

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

m | w | S

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

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

10-11-1929

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

X | 1 | 14

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)

14. INFORMANT (Address)

15. FILED 11/8 30 1929 J.A. Kiscock REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/25 1929

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

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CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. ds.

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IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

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

bedard grove, mo 11/26 1929

20. UNDERTAKER

none ADDRESS 1

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. Error Statement of OCCUPATION is very important.

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