

JUN 26

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

Do not use this space.

16609

1. PLACE OF DEATH

County Linn
Township Strom
City Aurora

Registration District No. 467
Primary Registration District No. 4280
(No. 8 West Capitol St)

File No. _____
Registered No. 203
-St- _____ Ward)

2. FULL NAME

Betty J. Hoover
(a) Residence. No. 8 West Capitol St., _____ Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF D.S. Hoover
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 7 2 1856
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 6 2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Tennessee

10. NAME OF FATHER Robert F Powers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) N. Carolina
12. MAIDEN NAME OF MOTHER Sarah Fletch
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

14. INFORMANT J. P. Powers
(Address) Chatham

15. FILED 6-1-30 REGISTRAR W. Smart

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24, 1930
17. I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 24, 1930, that I last saw her alive on May 24, 1930, and that death occurred, on the date stated above, at _____ 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary hemorrhage
1143
_____ (duration) _____ yrs. _____ mos. _____ ds.

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

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 CONFIRMED DIAGNOSIS? Clinical
(Signed) Thomas D. Miller, M. D.
, 19 _____ (Address) Aurora, Ill.

*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 Maple Park DATE OF BURIAL May 25 1930

20. UNDERTAKER Free Funeral Home ADDRESS Aurora Mo

Exact statement of OCCUPATION is very important. AGE should be carefully suppressed. AGE should be stated EXACTLY. BIRTH in plain terms, so that it may be properly classified.

**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 Lawrence
Township
City Aurora (No.)

Registration District No. 467
Primary Registration District No. 4280

File No.
Registered No. 203
St. Ward

2. FULL NAME

(a) Residence. No. Betty J. Hoover 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 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.

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 6-1-30 W. J. Hoover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24, 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Pulmonary hemorrhage
The attending physician
states he does not know.

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

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. PHYSICIAN'S NAME should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION OF DEATH is VITAL.

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

SUPPLEMENTARY

10702

S-16609