

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

10581
Do not use this space.

1. PLACE OF DEATH

(a) County Carter Registration District No. 146
 (b) Township Pike Primary Registration District No. 5209
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Preston Winfield Hoagland
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 Dora Leah Hoagland
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-6-1860
 7. AGE YEARS 79 MONTHS 5 DAYS 8 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) 1936 11. Total time (years) spent in this occupation 40 yrs

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 14 1940
 22. I HEREBY CERTIFY, That I attended deceased from 2-5 1940, to 2-14 1940
 I last saw him alive on 2-13 1940. Death is said to have occurred on the date stated above, at 4 A. M.
 The principal cause of death and related causes of importance were as follows:
Cardio-nephritis Date of onset 1938
 Other contributory causes of importance Serum

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cole Co. Ill. 1
 FATHER 13. NAME Samuel Porter Hoagland
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 9
 MOTHER 15. MAIDEN NAME Sarah Cothine Breakley
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 9
 17. INFORMANT (ADDRESS) George Hoagland
Frankfort Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Dry Valley DATE Feb. 15 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Duncan
727 View Mo
 20. FILED Apr. 7 1940 Jessie D. Schupp 138 (Address) Local Registrar

Name of operation _____ Date of _____
 What test confirmed diagnosis? direct Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Wm. H. Burton M. D.
Jan Buren, Mo. (Address)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

.....
working under my personal supervision.

RECEIVED

District Health Officer No. B,

Signed.....

District File Number 440 425

Licensed Embalmer No.....

Date Filed 4/11/40

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 105-81

Registration District No. 146

Primary Registration District No. 529

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carter
 (b) City or town Blue Jay
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carter
 (c) City or town Fremont
(If outside city or town limits write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) **Full name**

Dorston Winfield Hoagland

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14
 year 1940 hour _____ minute _____ M.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day _____ min.

79

5

8

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 1, 1940

(Date received local registrar)

(b) Jessie J. Schupp

(Registrar's signature)

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(City or town)

(County)

(State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)

While at work?

(e) Means of injury _____

23. Signature W.M. H. Buxton (M. D. or other) _____

Address Dan Buxton Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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