

Registration District No. 99 065 32 10Primary Registration District No. 8147Registrar's No. 10

## 1. PLACE OF DEATH:

(a) County Caldwell  
(b) City or town Polo, Rural, Rockford  
(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 \_\_\_\_\_

In this community 80 years (Specify whether  
years, months or days) 73. (a) PRINT FULL NAME Seth Hootman3. (b) If veteran, name war ✓ 3. (c) Social Security No. 1-4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If

7. Birth date of deceased May 3 - 1849.  
(Month) (Day) (Year)8. AGE: Years 91 Months 2 Days 10 If less than one day  
hr. min.9. Birthplace Frescarawas Co. Ohio  
(City, town, or county) (State or foreign country)10. Usual occupation Carpenter

## 11. Industry or business

12. Name Isaac Hootman13. Birthplace Ohio  
(City, town, or county) (State or foreign country)14. Maiden name Jafrona Hammerstein15. Birthplace Ohio  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Belle Pollard(b) Address Polo, Mo. R 217. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Marable Cemetery18. (a) Signature of funeral director Chamer Clark(b) Address Kingston Missouri19. (a) Aug 30 - 40 (b) Mar Wylie Thompson  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(b) State Mo (b) County Caldwell(c) City or town Rural  
(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.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug, day 13  
year 1940 hour 12:05 minute PT M.21. I hereby certify that I attended the deceased from Aug 12  
\_\_\_\_\_, 1940, to Aug 13, 1940that I last saw him alive on Aug 12, 1940,  
and that death occurred on the date and hour stated above.Immediate cause of death Acute Nephritis Duration  
with Coma. 36 hrsDue to Senile GangreneDue to Senile Gangrene  
both legs 2 weeksOther conditions Arteriosclerosis ?  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically

## 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?  
13While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_23. Signature CH Wilson (M. D. or other) 1Address Polo Mo Date signed 8/14/40

120

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**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~~.....

Cramer Clark....., Registered Apprentice No.....  
working under my personal supervision.

Signed Cramer Clark.....

Licensed Embalmer No. 3257.....

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

State File No. **31530**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **99**

Primary Registration District No. **5147**

Registrar's No. **10**

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

1. PLACE OF DEATH

(a) County **Caldwell**  
(b) City or town **Poals**  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME **Seth Hootman**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

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 **91** Months **2** Days **10** If less than one year \_\_\_\_\_ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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 (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH \_\_\_\_\_ month \_\_\_\_\_ day **13**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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.

Immediate cause of death **acute nephritis**

**with coma following**

**old chronic pyelitis**

**leg**

**arterio sclerosis**

**leg**

Due to \_\_\_\_\_

(Other conditions \_\_\_\_\_)

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 **C. H. Wilbur** (M. D. number)

Address **Poals Mo** Date signed **11/18/40**

