

FILED JUL 24 1942

Registration District No.

Primary Registration District No. 3004

State File No.

Registrar's No. 31

1. PLACE OF DEATH

(a) County BATES
(b) City or town BUTLER MO - 805 W OHIO
(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 23 years
years, months or days

3. (a) PRINT FULL NAME ELSIE JOSEPHINE HOOTS

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

4. Sex F 1 Color or race W 6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife CLAUDE HOOTS 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased APRIL 20 1900
(Month) (Day) (Year)

8. AGE: Years 42 Months 2 Days 21 If less than one day hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name ISSAC CLARK

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

14. Maiden name ELLEN CLARK

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

16. (a) Informant Claude Hoots

(b) Address Butler Mo

17. (a) Burial (b) Date thereof 7-13-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakhill

18. (a) Signature of funeral director Booth

(b) Address Butler Mo

19. (a) July 13 1942 (b) Mrs L Culver
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BATES
(c) City or town BUTLER MO
(If outside city or town limits, write "RURAL")
(d) Street No. 805 W OHIO
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1942 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from June 6 1942 to June 11 1942
that I last saw h. ER alive on June 11 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Stroke

Due to Operation for peptic ulcer
Due to operation June 15th

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature L D LaHue (M.D. or other)

Address Butler Mo Date signed 7-13-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number 7-42-810

Date Filed 7-23-42

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.

Signed.....

John G. Henderson

Licensed Embalmer No. 3585

P. O. Address Butler Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20592

Registration District No. 50

Primary Registration District No. 3004

Registrar's No. _____

1. PLACE OF DEATH: Bates Butler

(a) County _____

(b) City or town _____
(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

3. (a) PRINT FULL NAME Elsie J. Hoots

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex W

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 am 20
(Month) (Day) (Year)

8. AGE: Years 42 Months 2 Days 30
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Year 1942 Hour _____ Minute _____ M.

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

Immediate cause of death _____

pelvic Abscess
Left Tuber infection
Not specific

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

23. Signature L. J. L... (M. D. or other) _____

Address Butler, Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

STATE OF NEW YORK

IN SENATE
January 10, 1911.

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN ANSWER TO A RESOLUTION PASSED BY THE SENATE
MAY 17, 1909.

ALBANY:
J. B. LIPPINCOTT COMPANY, PRINTERS.
1911.