

2
42
-39
328

FILED MAR 27 1948

Registration District No.

Primary Registration District No.

2000

Registrar's No. 216

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O'Reilly General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 112 days
(Specify whether years, months or days)
In this community 112 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Nebraska (b) County Morrill
(c) City or town Bayard
(If outside city or town limits, write "RURAL")
(d) Street No. (none)
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country USA

3. (a) PRINT FULL NAME EMMETT E. HOOVER

3. (b) If veteran, name war WORLD WAR II
3. (c) Social Security No. UNK.

4. Sex Male 5. Color or Race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Martha Heil Hoover
6. (c) Age of husband or wife if alive UNK. years

7. Birth date of deceased January 3 1914
(Month) (Day) (Year)

8. AGE:				If less than one day
Years	Months	Days	hr. min.	
<input checked="" type="checkbox"/>	<u>30</u>	<u>2</u>	<u>0</u>	

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

10. Usual occupation Clerk

11. Industry or business Hardware Store

12. Name Adam Hoover

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

14. Maiden name Mollie Wolf

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

16. (a) Informant Mrs. Martha Hoover

(b) Address Bayard, Nebraska

17. (a) Removal (b) Date thereof Mar. 5, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bayard, Nebraska

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) 3-4-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3
year 1944 hour 9 minute 43 P. M.

21. I hereby certify that I attended the deceased from November 13, 1944, to March 3, 1944
that I last saw him in alive on March 3, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Adenocarcinoma, stomach, with extension to gastro-hepatic, gastrocolic, and gastro-splenic ligaments; with metastases to peritoneum and liver, cause undetermined.
Duration 6 mos.

Other conditions 46 lb
(Include pregnancy within 3 months of death)

Major findings: Inoperable carcinoma
Of operations

Of autopsy Confirmation of above diagnosis.

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 [Signature] (M. D. or other)
Address O'Reilly General Hospital Date signed 3/4/44

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

MOTHER FATHER

APR 10 1944

APR 12 1944

NOV 10 1954

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.....

Sam S. Lotewy

Licensed Embalmer No.

2457

P. O. Address.....

Springfield

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.

X