

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 13 1944
149

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33200

State File No. _____
Registrar's No. **4239**

Registration District No. _____ Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **JACKSON**
(b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ST. MARY'S HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1** (Specify whether years, months or days) **50 yrs.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **KANSAS** (b) County **WYANDOTTE**
(c) City or town **EDWARDSVILLE** **999**
(If outside city or town limits, write "RURAL") **14**
(d) Street No. **LAKE OF FOREST** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **HEBER HOLBROOK HOAR**
(b) If veteran, name war **NO.** (c) Social Security No. **702-12-1049**

MEDICAL CERTIFICATION
10. DATE OF DEATH: Month **OCTOBER** day **20** year **1944** hour **9** minute **30 AM.**

4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **(MARRIED)**
6. (b) Name of husband or wife **HATTIE I.** 6. (c) Age of husband or wife if alive **61** years
7. Birth date of deceased **JUNE 21, 1882**
(Month) (Day) (Year)

11. I hereby certify that I attended the deceased from **10-20-44** to **10-20-44** that I last saw him alive on **10-20-44** and that death occurred on the date and hour stated above.

8. AGE: Years **62** Months **3** Days **30** If less than one day hr. _____ min. _____

Immediate cause of death **Acute coronary thrombosis Pericarditis** Duration _____

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

Due to **Acute nephritis superimposed on chronic nephritis**

10. Usual occupation **ASST. TREASURER**

Other conditions **Arthritis deformans**
(Include pregnancy within 3 months of death)

11. Industry or business **K.C. SOUTHERN RR.**

Major findings: Of operations **0** Of autopsy **see above**

12. Name **ROBERT J. HOAR**

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

14. Maiden name **LUELLA PATTON**

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

16. (a) Informant **Mrs. Hattie I. Hoar**
(b) Address **Edwardsville Kans**

17. (a) **Removal** (b) Date thereof **10-20-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Hope Cem. near Edwardsville, Mo.**

18. (a) Signature of funeral director **Geo. N. Long**
(b) Address **St. Louis**

19. (a) **Oct 23 1944** (b) **J. E. Brown**
(Date received local registrar) (Registrar's signature)

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) **NO**
(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 **W. J. Mella** (M. D. or other) _____
Address **800 Argyle** Date signed **10-20-44**

APR 20 1945

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..... *Chas. H. Rider*.....

Licensed Embalmer No..... *3404*.....

P. O. Address..... *703 N. 10, K.C., 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.