

S. No. 2
M-2-43
7-5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1927

FILED FEB 13, 1945

Registration District No. _____ Primary Registration District No. 3011 Registrar's No. 2

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

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Staton Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution _____ (Specify whether
in this community _____ lifetime years, months or days)

3. (a) PRINT FULL NAME CHARLES CLARENCE HOOG
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married 0
divorced Infant
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Dec 31 1944
(Month) (Day) (Year)

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

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER
12. Name Lois R Hoog
13. Birthplace Cassville Mo
(City, town, or county) (State or foreign country)

14. Maiden name Emma May Ward
15. Birthplace Norwich Kans
(City, town, or county) (State or foreign country)

16. (a) Informant Lois R Hoog
(b) Address Carrollton Mo
(c) Place: burial or cremation Cassville Mo
(Burial, cremation, or removal) (Date thereof) Jan 4 1945
(Month) (Day) (Year)

18. (a) Signature of funeral director Stanley
(b) Address Carrollton Mo

19. (a) 1-3-'45 (Data received local registrar) (b) Mr James R. Paffety (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Carroll
(c) City or town Carrollton
(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 Jan day 3
year 1945 hour 3 minute 00 P.M.
21. I hereby certify that I attended the deceased from Dec 31
1944, to Jan 3 1945
that I last saw him/alive on Jan 3 1945
and that death occurred on the date and hour stated above.

Immediate cause of death General weakness since birth
Duration _____

Due to _____
Due to 158

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

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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? _____

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

23. Signature P. Hamilton Staton (M. D. or other) MD
Address Carrollton, Mo Date signed Jan 3 1945

RECEIVED

District Health Officer No 8,

File Number.....

Date Filed..... 2-10-48

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

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, fact should be so stated above.