

S. No. 2
M-243
5-17-39
PI X35697

FILED JUN 28 1945
Registration District No. 27

Primary Registration District No. 6290

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

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Buffalo ^{MO} Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: So. Benton Twp !
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 52 yrs
(Specify whether years, months or days)

In this community 52 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas ³⁰

(c) City or town 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME NANCY A. HOOVER

3. (b) If veteran, name war 0

3. (c) Social Security No. 0

4. Sex Female 5. Color or race w

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife 0 6. (c) Age of husband or wife if alive 10 years

7. Birth date of deceased Nov 10 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 8
If less than one day hr. 0 min. 0

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

10. Usual occupation House Keeping

11. Industry or business 0

MOTHER FATHER

12. Name Wilson Adams

13. Birthplace Mo 1
(City, town, or county) (State or foreign country)

14. Maiden name Ann Hedderford

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

16. (a) Informant Arthur D. Hoover

(b) Address Buffalo MO

17. (a) Burial (b) Date thereof 5-22-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation wt Pleasant

18. (a) Signature of funeral director L B Jones

(b) Address Buffalo Mo

19. (a) May 31-1945 (b) D. M. A. Hoover
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1945 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from 5-17-45
10:45 to 5-18-45 1945

that I last saw her alive on 5-18-45
and that death occurred on the date and hour stated above. 1945

Immediate cause of death apoplexy

Due to 0

Due to 0

Other conditions Age 83
(Include pregnancy within 3 months of death)

Major findings:
Of operations 0

Of autopsy 0

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

While at work? 0 (Specify type of place) Means of injury 0

23. Signature D. M. A. Hoover M. D. or other 0

Address Buffalo Mo Date signed 5-31-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1124

RECEIVED

Deputy Health Officer No. 7

License No. 6-15-714

Date Filed 7-25-45

FEB 6 1951

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 *Marion B. Jones*

Licensed Embalmer No. *4322*

P. O. Address *Buffalo, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Aug

Registration District No.

97

Primary Registration District No.

6290

Registrar's No.

430

1. PLACE OF DEATH:

- (a) County Dallas
 (b) City or town Rural S. Benton Twp
 (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 NAMENancy A. Hoover

3. (b) If veteran,
-
- name war _____

3. (c) Social Security
-
- No. _____

4. Sex
- F

5. Color or
-
- race
- w

6. (a) Single, widowed, married,
-
- divorced
- wed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
-
- alive _____ years

7. Birth date of deceased
- no
-
- (Month) _____ (Day) _____ (Year) _____

8. AGE: Years
- 74
- Months _____ Days _____
-
- If less than one day _____ hr. _____ min.

9. Birthplace _____
-
- (City, town, or county)

- (State or foreign country)
- Mo

10. Usual occupation _____

11. Industry or business _____

- MOTHER FATHER { 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 Mo (b) County Dallas
 (c) City or town Buffalo Rural
 (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 _____
-
- year
- 1943
- hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

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 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?

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY 8

23848