S. No. 2
M—8-43
v. 5-17-39
I X37823

34985

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 14 1945

State File No. .....

Registration District No. 373 Primary Registration District No. 6269 Registrar's No. 57

1. PLACE OF DEATH:

(a) County Webster Co

(b) City or town Fordland Rural Ozark (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution RFD #1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community 31 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Webster 112

(c) City or town Fordland RFD #1 0 (If outside city or town limits, write "RURAL")

(d) Street No. RFD #1 0 (If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME CHARLES ALVIN HOAGLAND

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Birdie

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Aug (Month) 18 (Day) 1872 (Year)

8. AGE: Years 73 Months 1 Days 19 If less than one day ..... hr. ..... min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Sam Hoagland

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

MOTHER 14. Maiden name Lebica Fackler

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

16. (a) Informant Glen W. Hoagland

(b) Address Fordland Mo

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-18-45 (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant View

18. (a) Signature of funeral director Lee Rainey

(b) Address Marshfield Mo

19. (a) 10-29-45 (Date received local registrar) (b) J. J. McTurney (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 17 year 1945 hour 2:00 minute A.M.

21. I hereby certify that I attended the deceased from December 15, 1944, to October 17, 1945; that I last saw him alive on October 14, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial Failure

Due to Chronic Myocarditis

Due to Hypertension Arteriosclerosis

Other conditions None. (Include pregnancy within 3 months of death)

Major findings: Of operations No operation

Of autopsy No autopsy

Duration

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)

(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 A. R. Schultz (M. D. or other) MD

Address Fordland Mo Date signed 10/20/45

15 60

(Licensed Embalmer's Statement on Reverse Side)

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

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 Lex Laney

Licensed Embalmer No. 3312

P. O. Address Marshfield 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.