

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

State File No. ....

Registrar's No. 598

FILED JUN 10 1946

Registration District No. 42

Primary Registration District No. 1000

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

1. PLACE OF DEATH:

(a) County BUCHANAN

(b) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
1523 MESSANIE STREET.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community MOST OF LIFE  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BUCHANAN

(c) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL")

(d) Street No. 1523 MESSANIE, ST.  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HOMER HOAG

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race NEGRO

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

6. (b) Name of husband or wife LULA HOAG

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

7. Birth date of deceased June 15 1856  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15th 1946

year \_\_\_\_\_ hour II minute 30 A. M.

21. I hereby certify that I attended the deceased from May 15th 1946 to \_\_\_\_\_ 19\_\_\_\_;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis and senility

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 89 Months 11 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation UNEMPLOYED

11. Industry or business NONE

MOTHER FATHER { 12. Name H. B. HOAG 9

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

14. Maiden name UNKNOWN

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

Major findings: Of operations ga

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. INA SMITH

(b) Address 222 IOWA STREET.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 20 1946  
(Month) (Day) (Year)

(c) Place: burial or cremation ASHLAND

18. (a) Signature of funeral director Beatrice Gray

(b) Address 812 Pacific

19. (a) May 24, 1946 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury \_\_\_\_\_

23. Signature B. W. Tadlock Coroner 3  
(M. D. or other)

Address King Hill Date signed 5/24/46

**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.....  
*Earl A. Clark*

Licensed Embalmer No. *4238*

P. O. Address *St. Joseph*

**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.**