

7. S. No. 2
FORM-8-43
Rev. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Busick

State File No. 30009

FILED OCT 8 9 1946

Registration District No. 28

Primary Registration District No. 2000

Registrar's No. 769

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Burge Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days (Specify whether years, months or days)
In this community 6 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
(c) City or town Mountain View
(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 _____

3. (a) PRINT FULL NAME

James Walter Hoover

3. (b) If veteran,

name war No

3. (c) Social Security

No. No

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced, single

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

7. Birth date of deceased July 21 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 2 2 hr. _____ min.

9. Birthplace West Plains Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name Arthur Edward Hoover

13. Birthplace Mountain View Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Emogene W. Lee

15. Birthplace Mountain View Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur E. Hoover

(b) Address Mountain View, Mo.

17. (a) Removal (b) Date thereof 9/24/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mountain View, Mo.

18. (c) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 9-24-46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23
year 1946 hour 5 minute 25p. M.

21. I hereby certify that I attended the deceased from 9-17, 1946, to 9-23, 1946
that I last saw him alive on 9-23-46, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous meningitis Duration 3wk

Due to Malinary Tuberculosis ?

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 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 [Signature] (M. D. or other) _____
Address Springfield, Mo. Date signed 9-24-46

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

MOTHER FATHER

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.....

Walter E Hamilton

Licensed Embalmer No.....

3808

P. O. Address.....

Springfield 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.

X