S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23062

Registration District No. 324 Primary Registration District No. 6092 Registrar's No. 138

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Grand Pass "Rural" (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2 1/2 Mi N. Grand Pass (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline 97
(c) City or town Grand Pass "Rural" (If outside city or town limits, write "RURAL")
(d) Street No. 2 1/2 Mi N. Grand Pass (If rural, give location)
(e) Citizen of foreign country? Mo (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ALBERT HOOVER
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ola Hoover
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Dec. 29 - 1881 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	65	5	22	hr. min.

9. Birthplace Malta Bend (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business —
FATHER
12. Name Riley Hoover
13. Birthplace (City, town, or county) Ohio (State or foreign country)
MOTHER
14. Maiden name Sarah Cave
15. Birthplace Carroll Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant Mrs Albert Hoover
(b) Address Grand Pass Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Grand Pass Community Cemetery Grand Pass Mo
18. (a) Signature of funeral director Harry Hershberger
(b) Address Marshall Mo
19. (a) June 26-1947 (Date received local registrar) (b) Sidney T. Gray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 year 1947 hour 5 minute 00 P M.
21. I hereby certify that I attended the deceased from 5 16 1946 to 6 21 1947 that I last saw him alive on 6 - 20 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	2 yrs
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 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 Geo A Kelling (M. D. or other)
Address Waverly Mo Date signed 6-23-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 7-11-47

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 Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall 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.