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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 24 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26088

Registration District No. 139 Primary Registration District No. 4224 Registrar's No. 28

1. PLACE OF DEATH:
(a) County Holt
(b) City or town Forest City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Forest City, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 6 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County BHolt 44
(c) City or town Forest City 0
(If outside city or town limits, write "RURAL")
(d) Street No. Forest City, Mo. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Samuel E. Hoover
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rosa B. Hoover
6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased January (Month) 9 (Day) 1874 (Year)

8. AGE: Years 74 Months 7 Days 0 If less than one day hr. min.

9. Birthplace Galion (City, town, or county) Ohio (State or foreign country)
10. Usual occupation Retired
11. Industry or business Methodist Minister
FATHER
12. Name Daniel Hoover
13. Birthplace Galion (City, town, or county) Ohio (State or foreign country)
MOTHER
14. Maiden name Ellen Wintrout
15. Birthplace Galion (City, town, or county) Ohio (State or foreign country)
16. (a) Informant Mrs. Rosa B. Hoover
(b) Address Forest City, Mo.
17. (a) Burial (Burial, cremation or removal) (b) Date thereof 8/12/48 (Month) (Day) (Year)
(c) Place burial or cremation Maple Grove Oregon, Mo.
18. (a) Signature of funeral director Heaton-Bowman
(b) Address St. Joseph, Mo.
19. (a) 8-27-48 (Date received local registrar) (b) J. C. Tracy (Registrar's signature) 12 22

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9
year 48 hour 10:11 minute 8 M.
21. I hereby certify that I attended the deceased from NO
, 19, to , 19;
that I last saw him alive on Aug 9, 1948;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: CORONARY OCCLUSION	15 MIN.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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 H. E. Collins 2 (M. D. or other) BO.
Address Oregon, Mo. Date signed Aug 10, 48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th, St. Joseph,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

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(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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 Samuel E. 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 9 (Day) 1 (Year)

8. AGE: Years 74 Months 7 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 8-27 (Date received local registrar) (b) 48 J C Gray (Registrar's signature)

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S - 26088 1948