

FILED MAR 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5403

State File No.

BIRTH NO. 124 REG. DIST. NO. 206 PRIMARY REG. DIST. NO. 5743 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Madison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Madison</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Star route, Marquand, Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural 31 Twp.</u>	
c. LENGTH OF STAY (In this place) <u>85 years</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Robert</u> c. (Last) <u>Hovis</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 3 1950</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 15 1865</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	11. BIRTHPLACE (State or foreign country) <u>Twp 31, Madison County Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Albert C. Hovis</u>	13b. MOTHER'S MAIDEN NAME <u>Hannah Graham</u>	14. NAME OF HUSBAND OR WIFE <u>Mary C. Shetley Hovis</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>--</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Wm Hovis</u>	Star Route Marquand, Mo
---	--------------------------------------	--	----------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Influenza</u>		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>6 Days</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mitral Insufficiency.</u> DUE TO (c)	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/27/50, 1950, to 3/3/50, 1950, that I last saw the deceased alive on Jan. 25, 1950, and that death occurred at 7.10 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Wm Hovis</u>	23b. ADDRESS <u>Fredericktown, Mo.</u>	23c. DATE SIGNED <u>3/4/50</u>
---	---	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>3/5/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>F.A. QUINN</u>	24d. LOCATION (City, town, or county) (State) <u>BULLKORN MO</u>
--	----------------------------	---	---

DATE REC'D BY LOCAL REG. <u>3-6-1950</u>	REGISTRAR'S SIGNATURE <u>Sherrill Jones</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>William Hovis</u>	ADDRESS <u>Fredericktown, Mo.</u>
---	--	--	--------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

670
1

RECEIVED

MAR 13 1950

DISTRICT HEALTH OFFICE No. 4

File No. 350-363

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed Frederick Adamson

Licensed Embalmer No. 4351

P. O. Address Fredericktown, Md

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.