

FILED MAR 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8536

1049

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1049				
1. PLACE OF DEATH a. COUNTY Jackson County				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY Ray		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) 3 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Norborne Mo.		0890		1		
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hoop.				d. STREET ADDRESS R.R. 2.						
3. NAME OF DECEASED (Type or Print) Elizabeth, M. Hoover			a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) March 8 1951	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct 29 - 1890		9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HR. Hours	IF UNDER 15 MIN. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work			10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Hector Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Aaron Culp			13b. MOTHER'S MAIDEN NAME Elizabeth (Miller)		14. NAME OF HUSBAND OR WIFE John H Hoover					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME John H Hoover						ADDRESS Norborne Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)										
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain tumor (?)								INTERVAL BETWEEN ONSET AND DEATH 4 mos		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.										
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								231 X		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 Mar 5, 1951, to Mar 8, 1951, that I last saw the deceased alive on Mar 8, 1951, and that death occurred at 3:45 p.m., from the causes and on the date stated above.										
23a. SIGNATURE Martin J. Mueller M.D.				23b. ADDRESS 934 Annye Bldg Kansas City Mo.		23c. DATE SIGNED Mar 8, 1951				
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE March 10 -	24c. NAME OF CEMETERY OR CREMATORY Fairchance Cemetery		24d. LOCATION (City, town, or county) (State) Norborne Missouri					
DATE REC'D BY LOCAL REG. 3-9-51		REGISTRAR'S SIGNATURE Geraldine Holmes			25. FUNERAL DIRECTOR'S SIGNATURE John G. Ditch					ADDRESS Norborne Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *John G. Ditch Sr.*

Licensed Embalmer No. *3654*

P. O. Address *Norburne 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.