

LED SEP 15 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30953

State File No. ....

BIRTH NO. .... REG. DIST. NO. 201 PRIMARY REG. DIST. NO. 3048 Registrar's No. 200

0742

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

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Nodaway</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Worth</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Maryville</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sheridan</b>  |  |
| c. LENGTH OF STAY (In this place) <b>4 days</b>   |  | 1130  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Saint Francis Hospital</b>                         |  | d. STREET ADDRESS (If rural, give location) <b>/</b>  |  |

|   |                          |                         |  |
|---|--------------------------|-------------------------|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Fred</b> | b. (Middle) <b>Clark</b> | c. (Last) <b>Hoover</b> | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>9-1-1951</b> |
|---|--------------------------|-------------------------|--|

|                    |                               |   |                                   |   |   |   |
|--------------------|-------------------------------|---|-----------------------------------|---|---|---|
| 5. SEX <b>male</b> | 6. COLOR OR RACE <b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b> | 8. DATE OF BIRTH <b>1 22 1886</b> | 9. AGE (In years last birthday) <b>65</b> | IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b> | IF UNDER 24 HRS. Hours <b></b> Min. <b></b> |
|--------------------|-------------------------------|---|-----------------------------------|---|---|---|

|   |   |  |  |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer-retired</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>farming-self</b> | 11. BIRTHPLACE (State or foreign country) <b>Wilsonville, Nebraska</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
|---|---|--|--|

|                                       |  |  |
|---------------------------------------|--|--|
| 13a. FATHER'S NAME <b>John Hoover</b> | 13b. MOTHER'S MAIDEN NAME <b>Alice Clark</b> | 14. NAME OF HUSBAND OR WIFE <b>Martha Edwards Hoover</b> |
|---------------------------------------|--|--|

|   |  |   |
|---|--|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Martha Hoover Sheridan, Mo.</b> |
|---|--|---|

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>   |  | <b>4 days</b>                    |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>arteriosclerotic heart disease with decompensation</b><br>DUE TO (c) <b></b> |  | <b>1 yr.</b>                     |
| II. OTHER SIGNIFICANT CONDITIONS*<br>Conditions contributing to the death but not related to the disease or condition causing death.  |   |  |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 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) (Min.) | 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 Nov 6, 1950 to 9-1, 1951, that I last saw the deceased alive on 8-31, 1951, and that death occurred at 5 A m., from the causes and on the date stated above.

|  |                                  |                                |
|--|----------------------------------|--------------------------------|
| 23a. SIGNATURE <b>J. A. Stordin M.D.</b> | 23b. ADDRESS <b>Bedford, Mo.</b> | 23c. DATE SIGNED <b>9/5/51</b> |
|--|----------------------------------|--------------------------------|

|   |                           |   |  |
|---|---------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> | 24b. DATE <b>9 4 1951</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>Lenox, Iowa</b> |
|---|---------------------------|---|--|

|  |  |  |
|--|--|--|
| DATE REC'D BY LOCAL REG. <b>8-8-51</b> | REGISTRAR'S SIGNATURE <b>Beas Holt</b> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John C. Dingle Grant City, Mo.</b> |
|--|--|--|



---

---

**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.

Student .....  
Student Embalmer

Signed Arch C. Duffer.....

Licensed Embalmer No. 3252.....

P. O. Address Grant City, 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.