

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**59-035062**

**FILED VS NOV 3 1959**

STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. \_\_\_\_\_ Registrar's No. 105

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Atchison</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Atchison</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Rock Port.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Rock Port.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>none</b>			Length of stay in 1b <b>X</b>	d. STREET ADDRESS (If outside, give location) <b>0030 none</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Clyde</b> Middle <b>Eugene</b> Last <b>Hoover</b>						4. DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>5-27-1903</b>	
9. AGE (In years last birthday) <b>56</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>29</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>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Feed Store</b>		11. BIRTHPLACE (City and state or country) <b>Shubert, Nebr.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>
13a. FATHER'S NAME <b>John Hoover</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Munsinger</b>			14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>			16. SOCIAL SECURITY NO. <b>515-05-0197</b>		17. INFORMANT <b>Lee Hoover, 910 10th St. Auburn, Nebr.,</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____				
			DUE TO (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>D. G. Galley</i>				(Degree or title) <b>Coroner</b>		22b. ADDRESS <b>Rock Port, Mo.</b>	
						22c. DATE SIGNED <b>10-27-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-26-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Shubert Cem.</b>		23d. LOCATION (City, town, or county) <b>Shubert, Nebr.,</b>		(State)
24. FUNERAL DIRECTOR <b>Bartholomew Mortuary, Rock Port.</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>Oct. 28, 1959</b>	
						26. REGISTRAR'S SIGNATURE <i>Thermin J. Schickel</i>	

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 All diseases in Part I must be causally related.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

**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 .....  
Signature of Student Embalmer

Signed *Graft Bartholomew* .....

Licensed Embalmer No...3173.....

P. O. Address Rock Port, 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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting. - -

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