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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

17486

FILED JUN 7 1945

Registration District No. 206 Primary Registration District No. 5743 State File No. Registrar's No. 29

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

1. PLACE OF DEATH:
(a) County Madison
(b) City or town Rural Big Creek township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Buckhorn 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 Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Madison
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Big Creek twp
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Lee HOVIS
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 Married
6. (b) Name of husband or wife Rose Ann HOVIS
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased Nov. 3 1875
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 4 If less than one day hr. min.

9. Birthplace Buckhorn Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Farming
11. Industry or business
FATHER
12. Name Albert C. Hovis
13. Birthplace Iron station N.C.
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Hanna Graham
15. Birthplace Buckhorn Mo.
(City, town, or county) (State or foreign country)
16. (a) Informant Byron Hovis
(b) Address Marquand Mo
17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof 5. 8. 45 (Month) (Day) (Year)
(c) Place: burial or cremation BUCKHORN, MO
18. (a) Signature of funeral director Ed Hovis
(b) Address Marquand Mo
19. (a) May 8 1945 (Date received local registrar) S. C. Slaughter (Registrar signature)
By C. B. ...

481

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7 year 1945 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from Apr. 26, 1944, to May 7, 1945;
that I last saw him alive on May 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency — Duration unknown
Due to
Due to
Other conditions Nephritis — unknown
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
Underline the cause to 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 S C Slaughter (M. D. or other)
Address 135 W. Main Fredericktown Mo Date signed May 8 1945

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 645-658
Date Filed 6-5-45

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 ....

Licensed Embalmer No. ....

P. O. Address ....

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.

No. 2B
—3-45
1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 206 Primary Registration District No. 5743 Registrar's No. 29

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

1. PLACE OF DEATH:
(a) County Madison
(b) City or town Rural Big Creek Twp.
(If outside city or town limits, write "RURAL" and name of township)
(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 John Lee Howis
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 Nov 3 [illegible] (Month) (Day) (Year)
8. AGE: Years 69 Months 6 Days If less than one day hr. min.
9. Birthplace (City, town, or county) MO (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 7 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 19 , to 19 ;
that I last saw h alive on 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to 131 b	
Other conditions (Include pregnancy within 3 months of death) Chronic [illegible]	
Major findings: Of operations	
Of autopsy	

SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN — Underline the cause to 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 M C Slaughter (M. D. or other)
Address Fredericktown Mo Date signed 6/16/45

SUPPLEMENTARY

17486