No. 2
1-10-39
17-89

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14915

FILED MAY 13 1940

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 377

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Springfield Baptist, Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one wk. (Specify whether
In this community life time
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Galloway
(If outside city or town limits, write "RURAL")

(d) Street No. Springfield, Mo. Rt. 5,
(If rural, give location)

(e) If foreign born, how long in U. S. A.? lifetime years.

3. (a) PRINT FULL NAME Donald Samuel Hooper

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 Divorced

6. (b) Name of husband or wife don't know

6. (c) Age of husband or wife if alive years

7. Birth date of deceased October (Month) 9, (Day) 1873 (Year)

8. AGE: Years 66 Months 6 Days 10 If less than one day hr. min.

9. Birthplace Rogersville, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Samuel Hooper
13. Birthplace Unknown (City, town, or county) Tenn, (State or foreign country)

MOTHER
14. Maiden name Mary J. Smith
15. Birthplace Rogersville, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Albert Hooper
(b) Address Galloway, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Galoway, Mo

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield, Mo.

19. (a) Apr. 21, 1940 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19
year 1940 hour 7 minute 55 A M.

21. I hereby certify that I attended the deceased from 4/8/, 1940, to 4/19/, 1940
that I last saw him alive on 4/19/40, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia with heart failure

Due to Chronic Myocarditis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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?
984 (Specify type of place)
While at work? (e) Means of injury

23. Signature C E Feller (M. D. or other)
Address Springfield Mo Date signed 4/20/40

(Licensed Embalmer's Statement on Reverse Side)

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 Floyd W. Fd

Licensed Embalmer No. 2910

P. O. Address 629 W Walnut

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.