

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24276**
Registrar's No. **2886**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County Jackson County
(b) City or town Kansasville Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Little Sisters of the Poor
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year 9 months
(Specify whether years, months or days) Now - Residents

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Leavenworth
(c) City or town St. Leavenworth, Kas.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Mary Hooker M. H.
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex F. 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John Hooker 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 26, 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____
MOTHER FATHER { 12. Name Daniel Kelly G.
18. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Rebecca Hales
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sister Bernelle
(b) Address 5331 Highland Ave.
17. (a) Removal (b) Date thereof 7/19/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Leavenworth, Kas. S.C. Davis and Co
18. (a) Signature of funeral director John T. Sherrin
(b) Address 184 Ches. Park
19. (a) July 19, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 19 1940
year _____ hour 3:30 minute 2 M.
21. I hereby certify that I attended the deceased from July 1, 1940, to July 17, 1940,
that I last saw he alive on July 14, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation Duration 3 weeks
Coronary arteriosclerosis
arteriosclerosis, general

Due to _____ 95B
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury 1
23. Signature John T. Sherrin (M. D. or other) M.D.
Address 1140 2nd Byrnt Bay Date signed 7-19-40

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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, above space should be left blank.