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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 9 1943

Registration District No. 170

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3033

State File No. 38531

Registrar's No.

**1. PLACE OF DEATH:**

(a) County LACLEDE

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

(c) Name of hospital or institution: WALLACE HOSPITAL O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 DAYS (Specify whether years, months or days)

In this community 6 DAYS

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County LACLEDE

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JESSE PAUL HOOPER JR.

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 SINGLE

6. (b) Name of husband or wife

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

7. Birth date of deceased NOV (Month) 1 (Day) 1943 (Year)

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

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

10. Usual occupation

11. Industry or business

FATHER
12. Name JESSE PAUL HOOPER
13. Birthplace LACLEDE Co (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name AUDRA OPAL CONN
15. Birthplace LACLEDE Co (City, town, or county) MO O (State or foreign country)

16. (a) Informant Mrs Bert Austin
(b) Address LEBANON Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-43 (Month) (Day) (Year)
(c) Place: burial or cremation ATKLEY CEM.

18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO

19. (a) Dec 1-43 (Date received local registrar) (b) Grace Roper (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month NOV. day 7TH. year 1943 hour 11 minute 40 A. M.

21. I hereby certify that I attended the deceased from 11/1 1943, to 11/7 1943, that I last saw him alive on 11/7 1943, and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Congenital cerebral | |
| Due to malformation | 6 days |
| 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature James L. Hope (M. D. or other)

Address Lebanon, Mo Date signed 11/9/43

1090

(Licensed Embalmer's Statement on Reverse Side)

Received .....

Laclede County Health Unit

File No. 11-43-167

Date Filed 12-8-43

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**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 D A Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon 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.**