S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29709

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3874

1. PLACE OF DEATH:

(a) County Jackson,
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Luke's Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 weeks (Specify whether
In this community 35 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City, 3
(If outside city or town limits, write "RURAL")
(d) Street No. 6128 Walnut Street, 8
(If rural, give location) 0
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x

3. (a) PRINT FULL NAME Mrs. Lucile D. Hoover,
3. (b) If veteran, name war no.
3. (c) Social Security No. no.
4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife W. G. Hoover,
6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased April (Month) 8 (Day) 1879 (Year)

8. AGE: Years 66 Months 5 Days ~~9~~ 8 If less than one day hr. min.

9. Birthplace Illinois (City, town, or county) (State or foreign country)
10. Usual occupation at home,
11. Industry or business x

FATHER
12. Name William O. Demrick
13. Birthplace Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Esther Stone
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant W. G. Hoover,
(b) Address 6128 Walnut St., Kansas City, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cemetery
18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 9-19-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 16th ~~xxxx~~ year 1945 hour 6:55 minute P. M.

21. I hereby certify that I attended the deceased from November 14, 1944, to September 16, 1945; that I last saw her alive on September 16, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Compression Myelitis	
Due to Degeneration of 5th Cervical Vertebra	
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 [signature] M. D. (M. D. or other)
Address K-C-2 Mo. Date signed 9/18/42

(Licensed Embalmer's Statement on Reverse Side)

Plaza med. P.M.
Body

Dr. Boughnow

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address K.C. 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.