

FILED SEP 29 1947

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 3959

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 Joseph Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 weeks
 (Specify whether
 In this community 22 years
 years, months or days)

3. (a) PRINT FULL NAME Flora L Hoover3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced married
 (b) Name of husband or wife Fred Hoover 6. (c) Age of husband or wife if alive 68 years
 7. Birth date of deceased: (Month) 4 (Day) 18 (Year) -

8. AGE: Years 65 Months _____ Days _____ If less than one day hr. _____ min. _____9. Birthplace Iowa (City, town, or county) _____ (State or foreign country) _____10. Usual occupation Housewife

11. Industry or business _____

12. Name Joseph Cozard 913. Birthplace unknown (City, town, or county) _____ (State or foreign country) _____14. Maiden name Clare Vandenberg15. Birthplace unknown (City, town, or county) _____ (State or foreign country) _____16. (a) Informant Fred Hoover(b) Address 5607 Halmer St17. (a) Burial (b) Date thereof: 9-18-47
(Burial, cremation, or removal) _____ (Month) (Day) (Year)(c) Place: burial or cremation MIDWAY18. (a) Signature of funeral director Steve McClure(b) Address Kansas City, MO19. (a) 9-17-47 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5607 Halmer St
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 16
year 1947 hour 9 minute _____ A. M.21. I hereby certify that I attended the deceased from Aug 27
1947 to Sept 16th 1947
that I last saw h. alive on Sept 15th 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Pastoral Intestinal Ob-
struction & perforation 2 da-
Due to of Stomach
adhesions from x-ray
Due to radiation therapy for
Carcinoma of Cecum 2 yrs.
ulcer & Metastases
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: 486

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 Jessie K Smith (M. D. or other) _____
 Address 318 Profley Rd Date signed 9/16/47

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

J. Alan Sheppard

Licensed Embalmer No. *4179*

P. O. Address *K. C. Mo*

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

If this body is not embalmed, fact should be so stated above.