

FILED NOV 16 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

36618

State File No.

Registrar's No. 4335

Registration District No. 149

Primary Registration District No. 1002

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:
D O A at General Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
(Specify whether
In this community 57 yrs
years, months or days)

3. (a) PRINT FULL NAME MINOR J. HOOVER
3. (b) If veteran, name war XXXXXXX no
3. (c) Social Security No. Unk.

4. Sex Male 5. Color or race Wh
6. (a) Single, widowed, married, divorced Wid.
6. (b) Name of husband or wife Opal Hoover
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased 4/1/1891
(Month) (Day) (Year)

8. AGE: Years 57 Months 06 Days 27
If less than one day hr. min.

9. Birthplace Kansas City Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Painter

11. Industry or business --
12. Name James Harrison Hoover
13. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Katherine A. Kerrigan
15. Birthplace Bradys Bend, Pa.
(City, town, or county) (State or foreign country)

16. (a) Informant John E. Hoover,
(b) Address 3420 Penn.
17. (a) Burial (b) Date thereof 10/26/48
(Burial, cremation, removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Marys Cem. Indep. Mo
18. (a) Signature of funeral director John P. Sheil
(b) Address Kansas City Mo
19. (a) 10-25-48 (b) Shaldine 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. 4006 Central
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 10 day 23
year 1948 hour 4 minute 30 P. M.
21. I hereby certify that I attended the deceased from Aug 30, 1948, to 10-23, 1948
that I last saw him alive on Aug Oct 23-48, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary failure (angina pectoris)
Due to Coronary sclerosis
Due to pt had previously had coronary occlusion
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations 1/3/11
Of autopsy

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?
Robert C. Davis (Specify type of place) 0
While at work? (c) Means of injury
23. Signature Robert C. Davis (M. D. or other)
Address 370 prof Bldg Date signed

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

MOTHER FATHER

Dr. R. C. Davis
Professional Bdg.,

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 John P. Shield
Licensed Embalmer No. 3625
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.