

FILED APR 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12055

State File No.

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **356-A**

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

| | | | |
|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Greene | |
| b. CITY (If outside corporate limits, write RURAL and give township) Springfield | | c. CITY (If outside corporate limits, write RURAL and give township) Brighton | |
| c. LENGTH OF STAY (In this place) 11 days | | d. STREET ADDRESS (If rural, give location) none | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital | | e. CITY OR TOWN 39 | |

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|-------------------------------------|--------------------------|------------------------|-------------------------|-------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Rickie | b. (Middle) Ray | c. (Last) Hoover | 4. DATE OF DEATH (Month) (Day) (Year) April 24, 1949 |
|-------------------------------------|--------------------------|------------------------|-------------------------|-------------------------------------------------------------|

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|--------------------|-------------------------------|-----------------------------------------------------------------------------|----------------------------------------|------------------------------------------|---------------------------------|--------------------------------|-----------------------------|
| 5. SEX Male | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married | 8. DATE OF BIRTH Sept. 25, 1947 | 9. AGE (In years last birthday) 1 | IF UNDER 1 YEAR Months 6 | IF UNDER 1 DAY Hours 27 | IF UNDER 12 HRS. Min. _____ |
|--------------------|-------------------------------|-----------------------------------------------------------------------------|----------------------------------------|------------------------------------------|---------------------------------|--------------------------------|-----------------------------|

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|---------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------|--------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | 10b. KIND OF BUSINESS OR INDUSTRY Child | 11. BIRTHPLACE (State or foreign country) Mo. O | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------|--------------------------------------------|

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|-------------------------------------------|-----------------------------------------------|-----------------------------------------|
| 13a. FATHER'S NAME Clyde C. Hoover | 13b. MOTHER'S MAIDEN NAME Marion Malen | 14. NAME OF HUSBAND OR WIFE none |
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|--------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------|---------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. no | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Norma Young Bright | ADDRESS _____ |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 1 mo |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ruptured appendix DUE TO (c) 501 | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Axlettaerus 50 Bronchopneumonia | | 2 wks | |

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| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|------------------------------|----------------------------------------|----------------------------------------------------------------------------------|

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|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) --- | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) --- | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------|

| | | |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? ✓ |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------|

22. I hereby certify that I attended the deceased from **4-10, 1949** to **4-21, 1949**, that I last saw the deceased alive on **4-21, 1949**, and that death occurred at **10:20 P.M.**, from the causes and on the date stated above.

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| 23a. SIGNATURE Urban Busch MD | (Degree or title) MD | 23b. ADDRESS Springfield Mo | 23c. DATE SIGNED 4-22-49 |
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|---------------------------------------------------------|---------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE April 24, 1949 | 24c. NAME OF CEMETERY OR CREMATORY Pleasant Hope Cemetery | 24d. LOCATION (City, town, or county) (State) Pleasant Hope Mo |
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|-----------------------------------------|----------------------------------------------|---------------------------------------------------------|---------------------------------|
| DATE REC'D BY LOCAL REG. 4/23/49 | REGISTRAR'S SIGNATURE W.E. Handley MD | 25. FUNERAL DIRECTOR'S SIGNATURE William B. Exum | ADDRESS Pleasant Hope Mo |
|-----------------------------------------|----------------------------------------------|---------------------------------------------------------|---------------------------------|

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

William B. Carwin

Licensed Embalmer No. *3092*

P. O. Address *Balmar, 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.