V.S. No. 300
Rev. 10.48

OCT 1

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33050

State File No. 33050

BIRTH NO. 4287 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8659

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Enroute City Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2269
d. STREET ADDRESS (If rural, give location): 1903a Blair Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Paula
b. (Middle): Jean
c. (Last): Hooker

4. DATE OF DEATH (Month) (Day) (Year): Sept. 14, 1952

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Jan. 4, 1952
9. AGE (In years last birthday): IF UNDER 1 YEAR Months: 8 Days: 10 IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.
13a. FATHER'S NAME: Oshell Dean Hooker
13b. MOTHER'S MAIDEN NAME: Pauline Brown
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Oshell Dean Hooker, Koch Hospital

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Congenital Cardiac

DUE TO (c) Hypertrophy

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 7544

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 9:40 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE Patrick E. Taylor (Degree or title) Coroner
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 9-15-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9-15-52
24c. NAME OF CEMETERY OR CREMATORY: Worthen
24d. LOCATION (City, town, or county) (State): Murphysboro, Ill.

DATE REC'D BY LOCAL REG.: SEP 15 1952
REGISTRAR'S SIGNATURE: J. Carl Smith, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H. Hoppe, 4700 Washington Blvd
(Licensed Embalmer's Statement on Reverse Side)

5 30 AM

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 J. Wm Binkley

Licensed Embalmer No. 3653

P. O. Address St Louis 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.