

FILED DEC 22 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42017**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1128**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Polk.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (in this place) 2 hrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Brighton 0840	
		d. STREET ADDRESS (If rural, give location) Star Rte. 1	

3. NAME OF DECEASED (Type or Print) a. (First) Jerry b. (Middle) Lewis c. (Last) Hoover			4. DATE OF DEATH (Month) (Day) (Year) Dec 16 1952		
5. SEX m	6. COLOR OR RACE w.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) child	8. DATE OF BIRTH May 7 - 1950	9. AGE (In years last birthday) 2	10. UNDER 1 YEAR 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Clyde Hoover		13b. MOTHER'S MAIDEN NAME Mamie Molen		14. NAME OF HUSBAND OR WIFE Child	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Father Clyde Hoover Hope Mo.	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema		DUE TO (b) myocarditis?					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) 4232					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Convulsive disorder					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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 **Dec. 15, 1952**, to **DEC. 16, 1952**, that I last saw the deceased alive on **Dec 16, 1952**, and that death occurred at **1 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Forest H. Harris M.D.		23b. ADDRESS St. Louis Children's Hosp.		23c. DATE SIGNED Dec. 16, 1952	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Dec. 18, 1952		24c. NAME OF CEMETERY OR CREMATORY Pleasant Hope	
24d. LOCATION (City, town, or county) (State) Hope Mo.		24e. FUNERAL DIRECTOR'S SIGNATURE W. D. Erwin			
DATE REC'D BY LOCAL REG. 12-17-52		REGISTRAR'S SIGNATURE Edith Williamson Registrar		ADDRESS Hope Mo.	

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

1005

1001

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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 L. Arthur Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield, 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.