

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1482**

FILED FEB 14 1953

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **266**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) 27 yrs.		d. STREET ADDRESS (If rural, give location) 6233 Harrison	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6234 Troost			
3. NAME OF DECEASED (Type or Print) a. (First) EARL		b. (Middle) F. c. (Last) HOOVER	
4. DATE OF DEATH (Month) (Day) (Year) 1 16 1953		5. SEX Male 6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Aug. 26, 1891	
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Abilene, Kansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Sam Hoover	
13b. MOTHER'S MAIDEN NAME Minnie Swanson		14. NAME OF HUSBAND OR WIFE Nellie E. Hoover	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.I 495-05-0297	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Nellie E. Hoover		ADDRESS 6233 Harrison	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 3 min	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) arteriosclerosis			
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4201	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **Jan 16, 1953**, to **Jan 16, 1953**, that I last saw the deceased alive on **Jan 16, 1953**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Sam D. Hooper (Degree or title) MD		23b. ADDRESS 6232 Troost Kansas City, Mo.		23c. DATE SIGNED Jan 17 53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/19/53		24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	
24d. LOCATION (City, town, or county) Kansas City, Mo.		24e. (State)			

DATE REC'D BY LOCAL REG. 1-17-53		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE FREEMAN MORTUARY & CHAPEL, K.C., MO.	
				ADDRESS	

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

Dr. Linn S. Hooper - De 5092
6232 Jewett - 8:30-5 -
For same at 4:30

FEB 16 1953

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 Clayton Barnes

Licensed Embalmer No. 4793

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.