

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18976**
2594

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

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 town) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 40 yrs		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: GEN. HOSP. # 2		e. STREET ADDRESS (If rural, give location) 1521 VIRGINIA 3268	
3. NAME OF DECEASED a. (First) WALTER		b. (Middle) _____ c. (Last) HOOBES	
4. DATE OF DEATH 6-2-1954		5. SEX 2 6. COLOR OR RACE MALE NEGRO	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH MAR. 7 1891	
9. AGE (in years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
11. BIRTHPLACE (City and State or Foreign Country) LITTLE ROCK, ARK.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME WALTER HOOBESS		13b. MOTHER'S MAIDEN NAME DONT KNOW	
14. NAME OF HUSBAND OR WIFE DONT KNOW		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Wm GORDON ADDRESS 1612 EUCLID K.C. 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cortic Resuscitation ANTECEDENT CAUSES Myocardial Insufficiency Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.	
23a. SIGNATURE Deputy Coroner I. M. Tillman M.D. (Degree or title)		23b. ADDRESS 1618 Lydia Ave.	
23c. DATE SIGNED 6/8/54		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 6-10-1954		24c. NAME OF CEMETERY OR CREMATORY BLUE ROSE LAWN	
24d. LOCATION (City, town, or county) (State) KANSAS CITY, Mo.		DATE REC'D BY LOCAL REG. 6-9-54	
REGISTRAR'S SIGNATURE Seraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE BRADY-BROWN ADDRESS K.C., Mo	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD I. M. Tillman

MC 5181

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John R. Bidmon*
Licensed Embalmer No...453
P. O. Address...*Kansas*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.