

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 15 1955

State File No. **7435**

BIRTH NO. _____ REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **4056** Registrar's No. **243**

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Butler	
b. CITY OR TOWN Fisk	c. LENGTH OF STAY (in this place) 15 yrs	c. CITY OR TOWN Fisk	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 In Fisk		STREET ADDRESS (If rural, give location) In Fisk	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle)	c. (Last) Hooker	4. DATE OF DEATH (Month) 3 (Day) 19 (Year) 55
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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 2-15-1885	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 1 Days 	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and State or Foreign Country) Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Columbus Hooker	13b. MOTHER'S MAIDEN NAME Rosa Nolan	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 489-18-5627	17. INFORMANT'S SIGNATURE OR NAME Carrie Harper, Fisk, Mo.	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, asthenia, 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) myo carditis		
	ANTECEDENT CAUSES Morbid 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 4222	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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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 Grover W. Wheeler (Degree or title) Coroner Poplar Bluff Mo	23b. ADDRESS Mar 21-55	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-23-55	24c. NAME OF CEMETERY OR CREMATORY Ash Hill	24d. LOCATION (City, town, or county) (State) Butler, Co. MO.
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DATE REC'D. BY LOCAL REG. 4/4/55	REGISTRAR'S SIGNATURE O. H. Muehleberg	25. FUNERAL DIRECTOR'S SIGNATURE J. C. White	ADDRESS Fisk, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

APR 11 1955

BUTLER CO. HEALTH DEPT

FILE No. _____

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 _____
Signature of Student Embalmer

Signed *Raymond L. Duffie*

Licensed Embalmer No. 47

P. O. Address *Bermu*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.