

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

Sheffer 11738  
State File No. 11738

No. 300  
10-48

FILED MAY 2 1955

0460

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

BIRTH NO. _____		REG. DIST. NO. <u>142</u>		PRIMARY REG. DIST. NO. <u>55676</u>		Registrar's No. <u>13</u>			
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>					
b. CITY OR TOWN <u>Mtn. View</u>		c. LENGTH OF STAY (in this place) <u>36 yrs</u>		c. CITY OR TOWN <u>Mtn. View</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>N. Lincoln</u>				e. STREET ADDRESS (If rural, give location) <u>N. Lincoln Star Pl.</u>					
3. NAME OF DECEASED (Type or Print) <u>Lester B. Hooper Sr.</u>			a. (First) <u>Lester</u>			b. (Middle) <u>B.</u>			
c. (Last) <u>Hooper Sr.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 24-1955</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>July 7-1874</u>			
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR <u>9</u> Months <u>17</u> Days		IF UNDER 4 HRS. <u>0</u> Hours <u>0</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>LAWYER</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Plattsburg, Mo.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13a. FATHER'S NAME <u>Robert Hooper</u>		13b. MOTHER'S MAIDEN NAME <u>Alice McClellan</u>		14. NAME OF HUSBAND OR WIFE <u>Zoolome Hooper</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. L. B. Hooper</u>					
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, asthma, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Renal decompensation</u>  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 _____				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) <u>Plattsburg, Mo.</u>					
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 <u>11:30</u> , 19 <u>55</u> , to <u>4:25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/29</u> , 19 <u>55</u> and that death occurred at <u>2:35 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>James R. Sheffer</u>				23b. ADDRESS <u>intw. view mo.</u>		23c. DATE SIGNED <u>4/29/55</u>			
24a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		24b. DATE <u>5-26-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City</u>		24d. LOCATION (City, town, or county) (State) <u>Plattsburg, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>4/28-55</u>		REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Durand General Home #1-17</u>					

(Licensed Embalmer's Statement on Reverse Side)

*James R. Sheffer MD*

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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.....  
Signature of Student Embalmer

Signed *Joel P. Duncan*

Licensed Embalmer No. *432*

P. O. Address *Mt. View, Pa.*

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.