

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13471**  
**2371**

FILED APR 27 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>Kirkwood</b> 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 <b>Barnes Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>444 Couch Ave</b>	
3. NAME OF DECEASED (Type or Print)	a. (First) <b>Alice</b>	(Middle) <b>M.</b>	c. (Last) <b>Hoover</b>
4. DATE OF DEATH	(Month) <b>March</b>	(Day) <b>15,</b>	(Year) <b>1955</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>Oct 20-1870</b>
9. AGE (In years) <b>84</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>25</b>	IF UNDER 2 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Kentucky</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Perry Shippy</b>	13b. MOTHER'S MAIDEN NAME <b>Laura Howe</b>	14. NAME OF HUSBAND OR WIFE <b>William Hoover</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b></b>	17. INFORMANT'S SIGNATURE OR NAME <b>444 Couch Ave</b>	ADDRESS <b>St. Louis</b>
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Lobar Pneumonia</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Gastroenteritis</b>  DUE TO (c) <b></b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerotic Heart Disease</b> <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b>  <b>3 wks.</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>490X</b>	
22. I hereby certify that I attended the deceased from <b>Feb. 28, 1955</b> , to <b>Mar. 15, 1955</b> , that I last saw the deceased alive on <b>Mar. 15, 1955</b> , and that death occurred at <b>3:15 AM</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Brand Michon Parker M. D.</b>	23b. ADDRESS <b>Barnes Hospital</b>	23c. DATE SIGNED <b>3/15/55</b>	
24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE <b>3/16/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Floral Park Cem</b>	24d. LOCATION (City, town, or county) (Specify) <b>Indianapolis Ind</b>
DATE REC'D BY LOCAL REG. <b>MAR 15 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>W. Louis H. Bopp Inc</b> ADDRESS <b>St. Louis</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

**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 *Ronald O. Johnson*

Licensed Embalmer No. *391*

P. O. Address *St. Louis*

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.