

FILED NOV 16 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35655**
9729

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 Missouri				b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 18 years		c. CITY OR TOWN St. Louis		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: St. Louis State Hospital				e. STREET ADDRESS (If rural, give location) 3121a Michigan Avenue								
3. NAME OF DECEASED (Type or Print) a. (First) Clara		b. (Middle) Marie		c. (Last) Hooss		4. DATE OF DEATH (Month) (Day) (Year) October 22, 1956						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH November 17, 1895		9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____	Hours _____	Mins. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Perry Co., Missouri		12. CITIZEN OF WHAT COUNTRY? USA						
13a. FATHER'S NAME Fred Bueckman			13b. MOTHER'S MAIDEN NAME Lydia Knapp			14. NAME OF HUSBAND OR WIFE Adolph H. Hooss						
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) None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Tillie Hooss,		ADDRESS 4045 Lafayette Ave.						
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mitral valve endocarditis				INTERVAL BETWEEN ONSET AND DEATH _____				
				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. Local acute peritonitis. Rt. breast carcinoma with metastasis								
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION to bones, spleen, lungs, liver				20. AUTOPSY? YES <input checked="" 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) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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 6-12 , 19 54 , to 10-22 , 19 56 , that I last saw the deceased alive on 10-22 , 19 56 , and that death occurred at 3:05 p.m. , from the causes and on the date stated above.												
23a. SIGNATURE Anna Hyman <i>Anna Hyman</i>						(Degree or title) MD		23b. ADDRESS 5400 Arsenal Street		23c. DATE SIGNED 10-23-56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 25, 1956		24c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery		24d. LOCATION (City, town, or county) St. Louis County, Missouri		(State) _____				
DATE REC'D BY LOCAL REG. OCT 24 1956		REGISTRAR'S SIGNATURE <i>Carl Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE BEIDERWIEDEN F.H., Inc.,		ADDRESS 1936 St. Louis Ave.						

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 *Delis J. Krispin*

Licensed Embalmer No. *349*

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.