

Health, Welfare, Public Service
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 Director, coroner, etc. must use only standard nomenclature in return to... no symptoms were observed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Cameron F. Marshall

FILED APR 10 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

1334

o 14749-57 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY LACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON				
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN OVERLAND PARK		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSP			Length of stay in lb 1 hr.		d. STREET ADDRESS 6514 MARTY		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARK Middle E. Last HOOVER				4. DATE OF DEATH Month 3 Day 20 Year 57				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-57		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) KANSAS CITY, MO		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN E. HOOVER z/r.				14. MOTHER'S MAIDEN NAME HELEN M. KINNEY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER			Address ABOVE
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Disturbance DUE TO (b) Prematurity DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 7625	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from Mar. 20, 1957 to Mar 20, 1957 and last saw her/him alive on 3/20/57 Death occurred at 10 P m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Cameron F. Marshall M.D.				22b. ADDRESS 2010 North Blvd. Kansas City Mo		22c. DATE SIGNED 3/22/57		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-22-57	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION		23d. LOCATION (City, town, or county) MISSION KANSAS		(State)	
24. FUNERAL DIRECTOR MELBODY-McGILLEY-EYAR			ADDRESS K.C. MO		25. DATE RECD. BY LOCAL REG. 3-22-57		26. REGISTRAR'S SIGNATURE Steve Minshall	

(Licensed Embalmer's Statement on Reverse Side)

Dr. Marshall
Ploza Theatre Bldg.
Till 4:30 PM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Arthur Eugene Ho*

Licensed Embalmer No. *49*

P. O. Address *K.C. Mo*

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

