

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4355

STATE FILE NUMBER

FILED MAY 19 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |  |   |   |   |  |  |  |   |  |
|--|--|---|---|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |  |  |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>  |  | Length of stay in 1b  |   | c. CITY OR TOWN <b>St. Louis</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>4227 A East Finney</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Kennard</b> Middle Last <b>Hooper</b>  |  |   |   | 4. DATE OF DEATH<br>Month <b>5</b> Day <b>4</b> Year <b>61</b>  |  |  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/26/1915</b>  |  | 9. AGE (last birthday) <b>45</b><br>IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Attendant</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Service Station</b>               |   | 11. BIRTHPLACE (City and state or country)<br><b>Brooklyn, Ill.</b>        |  | 12. CITIZEN OF WHAT COUNTRY  |   |  |
| 13a. FATHER'S NAME<br><b>Alfred Hooper</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Cora Lucas</b>                            |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>---</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |   | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>Elizabeth Anderson, 2516 Chester</b>           |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Meningitis</b><br>DUE TO (b) <b>340.3</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Undet.</b>                          |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  |   |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 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<br>Hour a.m. p.m.  |  | Month, Day, Year  |   |   |  |  |  |   |  |
| 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 <b>5-3-61, 6:15 a.m.</b> to <b>5-4-61</b> and last saw <sup>ix</sup> him alive on <b>5-4-61</b><br>Death occurred at <b>8:25</b> a. m on the date stated above, and to the best of my knowledge, from the causes stated.                                |  |   |   |   |  |  |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><i>Sydney A. Frase, M.D.</i>   |  |   |   |   | 22b. ADDRESS<br><b>2601 N. Whittier St.</b>                                |  | 22c. DATE SIGNED<br><b>5-5-61</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 23b. DATE<br><b>5/9/61</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Park Cem.</b>         |   | 23d. LOCATION (City, town, or county)<br><b>Berkley City, Mo.</b>          |  | (State)  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Cunningham &amp; Moore, 2405 Marcus Av</b>  |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 8 1961</b>   |  | 26. REGISTRAR'S SIGNATURE<br><i>Loan Smith, M.D.</i>   |  |   |  |

**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 John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus Av

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.