

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3622
3622-61-025235
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

FILED AUG 8 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 53 YEARS	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Hyde Park Hotel 36th & Broadway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ADA Middle Last HOOVER			4. DATE OF DEATH Month July Day 18 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/18/1885	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist - PARTNER		10b. KIND OF BUSINESS OR INDUSTRY HUGO BRECKENRIDGE Drugs & SON.		11. BIRTHPLACE (City and state or country) Mansfield, Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME David Hoover		13b. MOTHER'S MAIDEN NAME Mary Jenkins		14. NAME OF HUSBAND OR WIFE -	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Address K. C., Mo. Sophia Thompson, 5000 Oak Street,
--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 36 HRS. months 3 yrs
IMMEDIATE CAUSE (a) Hypostatic Pneumonia		
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last. DUE TO (b) metastatic Ca. lungs		
DUE TO (c) Ca of 4 years		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 1946 to 1961-7-18 and last saw her alive on 18 July 61
Death occurred at 1:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert M. Myers M.P.	22b. ADDRESS 906 Grand Ave	22c. DATE SIGNED 19 July 61
---	--------------------------------------	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/20/1961	23c. NAME OF CEMETERY OR CREMATOR -	23d. LOCATION (City, town, or county) (State) Mansfield, Missouri
--	-------------------------------	---	---

24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 7-20-61	26. REGISTRAR'S SIGNATURE Ruth Long
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
ITEM NO. SHOULD READ

DOCUMENT
BY AFFIDAVIT OF
Robert M. Myers

MEDICAL CERTIFICATION

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 W. Harold E. Eckert

Licensed Embalmer No. 3035

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.