SEP 22 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
26065

1. PLACE OF DEATH
County: Callaway Registration District No.: 111
Township: Kingsandoseia Primary Registration District No.: 5Ho
City: (No. ..... St. ..... Ward)
File No.:
Registered No.:

2. FULL NAME: Ela Hopkins
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: —
6. DATE OF BIRTH (MONTH, DAY AND YEAR): May - 8 - 1889
7. AGE: YEARS 41 | MONTHS 3 | DAYS 17 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DEECEASED
(a) Trade, profession, or particular kind of work: House woman.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN): Fulton
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Jack Hathright
11. BIRTHPLACE OF FATHER (CITY OR TOWN): —
(STATE OR COUNTRY): Callaway Co. Mo.
12. MAIDEN NAME OF MOTHER: Jane Radican
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): —
(STATE OR COUNTRY): Franklin Co. Mo.

14. INFORMANT: Willie Hathright
(Address): Mexico Mo
15. FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 25 1930
17. I HEREBY CERTIFY, That I attended deceased from Aug 25, 19 30, to Aug 25, 19 30 that I last saw h. alive on Aug 25, 19 30 and that death occurred, on the date stated above, at 2 00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Post Partum Hemorrhage
1 hr
1 hr
..... (duration) ..... yrs. ..... mos. 6 hr ds.
CONTRIBUTORY (SECONDARY): Placenta Previa
to take to return to
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED: Fulton Mo
IF NOT AT PLACE OF DEATH:
DID AN OPERATION PRECEDE DEATH? No DATE OF:
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed): J. B. Parsons, M. D.
, 19 (Address): Mexico

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Oakley Cemetery — DATE OF BURIAL: 8-27 1930
20. UNDERTAKER: C. W. Musgrove — ADDRESS: Mokane, Mo

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Callaway — Registration District No. 111 — File No. .....

Township Catesandesmen — Primary Registration District No. 3-161 — Registered No. .....

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Ela Hopkins

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	Col	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED ....., 19 M. L. Hood, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 23 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. [illegible] should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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