

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

Do not use this space.

36355

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Law Primary Registration District No. 1002
City Jackson Mo. (No. General Hosp #2) St. _____ Ward _____

File No. _____
Registered No. 4775
St. _____ Ward _____

2. FULL NAME

Leona Hopkins
(a) Residence. No. 1638 Morton 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 Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-25-1910

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>19</u>	<u>20</u>	<u>11</u>	<u>27</u>	

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

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

10. NAME OF FATHER W. H. Weber

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

12. MAIDEN NAME OF MOTHER Clara Clark

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

14. INFORMANT Leota Griffin
(Address) 1640 Morton

15. FILED 11/25/30 M. M. Brown
REGISTRAR
Ass't

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-22 1930

17. I HEREBY CERTIFY, That I attended deceased from 11-8-
1930 to 11-22 1930
that I last saw her alive on 11-22 1930, and that death occurred, on the date stated above, at 10:0 A m.

THE CAUSE OF DEATH WAS AS FOLLOWS

1. Intestinal obstruction caused by post-operative adhesions
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Unknown
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Unknown
IF NOT A PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF 11-8-30

WAS THERE AN AUTOPSY? yes 11-21-30

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) D. N. Miller, M. D.
11/23, 1930 (Address) General Hospital #2

*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 Blue Ridge Lawn Cemetery DATE OF BURIAL 11-26 1930

20. UNDERTAKER Superior Undertaking Co. ADDRESS 2102-Vine St.

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.

