

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FEB 28 1935

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

Do not use this space.

2490

1. PLACE OF DEATH

County Dick Registration District No. 703
Township Johnson Primary Registration District No. 4424
City Humansville (No. _____) St. _____ Ward _____

2. FULL NAME

Clara Belle Hopper
(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 <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>W. C. Hopper</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 9, 1870</u>		
7. AGE <u>64</u>	YEARS <u>4</u>	MONTHS <u>2</u>
		DAYS <u>2</u>
		IF LESS THAN 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Nurse</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill. Mansfield, Ill.</u>		
FATHER	13. NAME <u>Anson D. Ott</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>	
MOTHER	15. MAIDEN NAME <u>Catherine Brown</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>	
17. INFORMANT <u>Will Ott</u> (ADDRESS) <u>Garden City, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>City Cemetery</u> DATE <u>Jan 13, 1935</u>		
19. UNDERTAKER <u>Ralph A. Joseph</u> (ADDRESS) <u>Humansville, Mo.</u>		
20. FILED <u>Jan. 15, 1935</u> <u>ORA M. RICH</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 11, 1935

22. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1935, to Jan 11, 1935

I last saw her alive on Jan 9, 1935 Death is said

to have occurred on the date stated above, at 1:15 p.m.

The principal cause of death and related causes of importance were as follows:

Cerebral apoplexy
Arterio Sclerosis

Date of onset

4 mos

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 1935

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) R. D. Neerins, M. D.

(Address) Humansville, Mo.

