REC'D APR 7 1939

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

11633
Do not use this space.

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.

1. PLACE OF DEATH
(a) County Montgomery
(b) Township
(c) City Montgomery City Mo (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 55 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 592
Primary Registration District No. 43650
Registered No. 8

2. PRINT FULL NAME Mrs Katie Hopkins
(a) Residence, No. Montgomery City Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2/24/1872

7. AGE: Years 67 | Months | Days 27 | If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 1937
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Readsville Mo

FATHER
13. NAME James Mc Mahan
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Readsville Mo

MOTHER
15. MAIDEN NAME Amanda Crews
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Readsville Mo

17. INFORMANT Clarence C. Hopkins
(ADDRESS) Montgomery City Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Montg City Cem DATE 8/23/39, 19

19. FUNERAL DIRECTOR (NAME) C. W. Hopkins
(ADDRESS) Montgomery City Mo

20. FILED Mar 22, 1939 Bull Menefee
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar-21, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1938, to Mar 21, 1939
I last saw him alive on Mar-21, 1939. Death is said to have occurred on the date stated above, at 7.45 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Encephalitis Lethargica (Epileptomorphic Type)	3-17-39
Hypostatic pneumonia (Bronchial)	3-19-39
Other contributory causes of importance: Arthritis joints of hands & knees	Dec. 1937

Name of operation Date of
What test confirmed diagnosis Clinical & Lab 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, 19
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) James A. Helm, M. D.
(Address) New Florence Mo

(Licensed Embalmer's Statement on Reverse Side)

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, the 2I st March I939, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. I487

P. O. Address Montgomery City Mo

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 this body is not embalmed, above space should be left blank.