

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33672**

Registrar's No. **8369**

NOV 16 1940 7911

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **4226 Prarie Ave.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Burch C. Hopkins**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Katie H. Hopkins** 6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **Oct. 22nd, 1876**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 **11** **15** _____ hr. _____ min.

9. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Accountant**

11. Industry or business **Retired**

12. Name **John W. Hopkins**

13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Moberlie**

15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Katie H. Hopkins**

(b) Address **4226 Prarie Ave.**

17. (a) **Burial** (b) Date thereof **10-9-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Lebanon Cemetery**

18. (a) Signature of funeral director **Drehmann Harral**

(b) Address **1905 Union Blvd.**

19. (a) **OCT 8 1940** (b) **J. J. R. R. R.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** 10
(If outside city or town limits, write "RURAL")
(d) Street No. **4226 Prarie Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **7th**
year **1940** hour **1** minute **A** M.

21. I hereby certify that I attended the deceased from _____, 1938, to **Oct 6th**, 1940;
that I last saw him alive on **Oct 6th 1940**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis of Myocardios** 24 hrs
Due to **Chronic Myocardios** 2 1/2 yrs

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. J. R. R. R.** (M. D. or other) _____
Address **3401 Lee Ave** Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr Mc Intyre 1-2
3801 Ave

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.....

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

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address.....

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, fact should be so stated above.