

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

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FILED SEP 26 1941

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

Do not use this space.

1. PLACE OF DEATH

County Gasconade
Township Richland
City (No. 1)

Registration District No. 304
Primary Registration District No. 5421

File No. 31526-27
Registered No. 304 Ward 0

2. FULL NAME Amalia Hoppe

Residence, No. 0 St. 0 Ward 0
(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>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF <u>Herman Hoppe</u> (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 15 1845</u>		
7. AGE YEARS <u>96</u>	MONTHS <u>1</u>	DAYS <u>10</u>
IF LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>House wife</u>	
	10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Pommern / Germany</u>	
	13. NAME <u>Wm Gust</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Pommern / Germany</u>	
	15. MAIDEN NAME <u>Untersaewer</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Untersaewer</u>	
17. INFORMANT <u>Herman Hoppe</u> (ADDRESS) <u>Prison No 1</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>In prison</u> DATE <u>Aug 28 1941</u>		
19. UNDERTAKER <u>Arnold Humbert</u> (ADDRESS) <u>Prison No 1</u>		
20. FILED 19 <u>5716</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 25 1941

22. I HEREBY CERTIFY, That I attended deceased from Aug 1 1941 to Aug 25 1941
I last saw her alive on Aug 25 1941 Death is said to have occurred on the date stated above, at 7 a.m.
The principal cause of death and related causes of importance were as follows:
Apoplectic stroke
Arteriosclerosis
Old age
Other contributory cause of importance: 830
rupt
Name of operation. rupt Date of June
What test confirmed diagnosis Physian was there an autopsy? True

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? _____
If so, specify _____
(Signed) Prof. Williams M. D.
(Address) Sum Mo

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Handwritten text in the upper right section, possibly a name.

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Handwritten text in the middle left section, possibly a date or number.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31526

Registration District No. 304

Primary Registration District No. 5421

Registrar's No. 304

1. PLACE OF DEATH: (a) County Gasconade
 (b) City or town Richland
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (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

USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Gasconade
 (c) City or town Marion mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? Germany (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Amalia Hoppe
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 00

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug Day 25
 year 1941 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____
 that I have seen him/her live on _____, 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: July 15 1884
 (Month) (Day) (Year)
 8. AGE: Years 26 Months 1 Days 4 If less than one day _____ min.

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

9. Birthplace (City, town, or county) _____ (State or foreign country) _____
 10. Usual occupation _____
 11. Industry or business _____
 12. Name _____
 13. Birthplace (City, town, or county) _____ (State or foreign country) _____
 14. Maiden name _____
 15. Birthplace (City, town, or county) _____ (State or foreign country) _____
 16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director _____
 (b) Address _____
 (c) 9-18-41 (b) F. L. Kicker
 (Date received local registrar) (Registrar's signature)

Major findings: Of operations _____
 Of autopsy _____
 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?
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature _____ (M: D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Planning

S-31526 -1941