

Registration District No. 89

Primary Registration District No. 2007

12
7
3
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Butler
 (b) City or town Poplar Bluff Mo.
 (c) Name of hospital or institution: Poplar Bluff Hospital
 (d) Length of stay: In hospital or institution Two Months
 In this community Years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Stoddard
 (c) City or town Bloomfield
 (d) Street No. _____
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME SARAH E. FOPAY

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife George Fopay 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased: 3- (Month) 30- (Day) 1889 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>6</u>	<u>25</u>	hr. min.

9. Birthplace Bollinger Co. Mo.

10. Usual occupation Housewife

11. Industry or business _____

12. Name Smith U. Watson

13. Birthplace Not known

14. Maiden name Cynthia Grady

15. Birthplace Not known

16. (a) Informant Mr. George Fopay

(b) Address Bloomfield, Mo.

17. (a) Burial (b) Date thereof 10-28-41

(c) Place: burial or cremation Bloomfield, Mo.

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) 11-9-41 (b) Belle Kimmel

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25 year 1941 hour 9 minute 52 P. M.

21. I hereby certify that I attended the deceased from Aug. 25, 1941, to Oct 25, 1941; that I last saw him alive on Oct 25, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Placenta

Due to Perforated peptic ulcer

Due to 1170

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

Major findings: Perforated peptic ulcer
Of autopsy none

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) not

(b) Date of occurrence _____

(c) Where did injury occur? _____

(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 0

23. Signature J. H. Kimmel (M. D. or other) _____

Address Poplar Bluff, Mo. Date signed _____

RECEIVED

District Health Office No. 2,

District File Number 1141-1559

Date Filed 11/13/41

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

James B. Lester Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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, fact should be so stated above.