

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. **6021**

Registration District No. **818**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

In this community 30 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County.....

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1106 No. 19th St.
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Charlie Clinton Hopkins

3. (b) If veteran, name war no

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or Race Col

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Oct. 16, 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

55 8 12 hr. min.

9. Birthplace Coffeerville, Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business Bedding Co.

MOTHER FATHER { 12. Name Coleman Hopkins

{ 13. Birthplace Coffeerville, Miss.
(City, town, or county) (State or foreign country)

{ 14. Maiden name Gertrude Schneider

{ 15. Birthplace Coffeerville, Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Lillian Higgins

(b) Address 1007a N. 23rd St.

17. (a) Burial (b) Date thereof 7/1/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Dement & Son

(b) Address 2629-31 Cole Street

19. (a) JUL 1 1943 (b) J. J. Budick
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1943 hour 12 minute 25 P.M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to Ruptured Aortic aneurysm

Due to.....

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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?
(Specify type of place)

While at work?..... (e) Means of injury.....

Signature Thomas F. Callahan (M. D. or other)
Address Deputy Coroner Date signed 7-2-43

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..... *William Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address... *4575 Alhine*

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.