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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20860

FILED JUN 29 1943
Registration District No. 42

Primary Registration District No. 1000

State File No. _____
Registrar's No. 607

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
In this community 6 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Rebecca Arminta Hopkins

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife George Hopkins 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 16 1849
(Month) (Day) (Year)

8. AGE: Years 93 Months 8 Days 13 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Abraham Butler
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Eunice Moasburger
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Eunice Knott
(b) Address 36th & Francis
17. (a) Burial (b) Date thereof 6-1-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lotts Grove
18. (a) Signature of funeral director Fleeman & Son Inc.
(b) Address 1946 Colhoun St.
19. (a) 6-1-43 (b) Rae Herzog
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 36th & Francis
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1943 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from May 20th 1943, to May 29 1943
that I last saw her alive on May 28 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Fractured femur
Arteriosclerosis
Senility over 1 yr.
Due to _____
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) Accident
(b) Date of occurrence May 20, 1943
(c) Where did injury occur? Home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? no (Specify type of place) (a) Means of injury _____
23. Signature Rae Herzog (M. D. or other) _____
Address St Joseph, Mo. Date signed 5/29/43

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

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

Robert H Apple

Licensed Embalmer No.

3308

P. O. Address

St Joseph, 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.

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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)

3. (a) PRINT FULL NAME Rebecca A. Hopkins
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Sept 16 (Month) (Day) (Year)

8. AGE: Years 93 Months 5 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May year 1943 hour _____ minute _____ M. 9
21. I hereby certify that I attended the deceased from _____ to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death: fracture femur right Duration _____

Due to arteriosclerosis and senility over 1 yd.
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: 1860
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) Accident

(b) Date of occurrence May 10 1943

(c) Where did injury occur? St Joseph Buchanan Mo (City of town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
(Specify type of place) (Means of injury) Foot

23. Signature Clayton Smith M.D. (M. D. or other)

Address Wellborn Road Date signed _____

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

SUPPLEMENTARY

20860