Form No. 2
M—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 6 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 44080

Registration District No. 260 — Primary Registration District No. 6225 — Registrar's No. 180

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Nevada; Rural-Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Washington Township
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 years (Specify whether)
In this community 17 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Washington Township
(If rural, give location)

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

3. (a) PRINT FULL NAME August Hoppe

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 17 (Month) (Day) 1856 (Year)

8. AGE: Years	Months	Days	If less than one day
86	11	26	hr. min.

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

10. Usual occupation Farming

11. Industry or business Farmer

FATHER
12. Name August Happe
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rosa Kreps
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Fred Happe (Son)
(b) Address Clinton Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-43 (Month) (Day) (Year)
(c) Place: burial or cremation Clinton, Mo

18. (a) Signature of funeral director Marsh Eichinger
(b) Address Nevada Mo

19. (a) 12-21-43 (Date received local registrar) (b) Hazel B. Beurck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21
year 43 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from Dec 1, 1943 to Dec 21, 1943
that I last saw him alive on Dec 20, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arterio-Sclerotic Heart disease	?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Senile dementia	?

Major findings:
Of operations —
Of autopsy no

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) no
(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 R. F. Kell (M. D. or other)
Address Nevada Mo Date signed 12/21/43

(Licensed Embalmer's Statement on Reverse Side)

1837

RECEIVED
District Health Officer No. 7,
District File Number 12-43-1411
Date Filed 1-5-44

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 Mark Erickson

Licensed Embalmer No. 2656

P. O. Address Nevada, 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.

S. No. 2B
GM—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan.

Registration District No. 36e Primary Registration District No. 6225 Registrar's No.

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp. No. 3.
(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 ____

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 ____

3. (a) PRINT FULL NAME August Hoppe
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive Unk years

7. Birth date of deceased Sept. (Month) 17 (Day) 1858 (Year)

8. AGE: Years 86 | Months 11 | Days ____ | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Germany (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) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) 1-14-44 (Date received local registrar) (b) Hazel B. Berwick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ____ Day ____ year ____ hour ____ minute ____ 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.

	Duration
Immediate cause of death	
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) ____
(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

S-44980