

FILED APR 12 1944  
Registration District No. **1944**

Primary Registration District No. **3002**

1. PLACE OF DEATH:

(a) County **Andrain**  
(b) City or town **Mexico**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Andrain Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **13 days**  
(Specify whether years, months or days)  
In this community **13 days**

3. (a) PRINT FULL NAME **Samuel Allen Hopper**

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

4. Sex **M**  
5. Color or race **W**  
6. (a) Single, widowed, married, divorced **2**

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

7. Birth date of deceased **Jan 19, 1877**  
(Month) (Day) (Year)

8. AGE: Years **67** Months **2** Days **6**  
If less than one day hr. min.

9. Birthplace **Calloway County, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Self**

12. Name **John J. Hopper**  
13. Birthplace **N. C.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mary S. Covington**

15. Birthplace **N. C.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Frank Atkinson**

(b) Address **Mexico, Mo.**

17. (a) **Burial** (b) Date thereof **3/26/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Williamsburg, Mo.**

18. (a) Signature of funeral director **[Signature]**

(b) Address **Mexico, Mo.**

19. (a) **3/26/44** (b) **Maragret H. Mackie**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Montgomery**  
(c) City or town **Montgomery City (Rural)**  
(If outside city or town limits, write "RURAL")  
(d) Street No.  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **25**  
year **1944** hour **2:50** minute **PM**

21. I hereby certify that I attended the deceased from **March 12** 19**44** to **March 25** 19**44**  
that I last saw him alive on **March 24** 19**44**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Acute cardiac failure**  
Duration **5 yrs**

Due to **Chronic myocarditis, enlargement**  
**Chronic nephritis, uremia**  
Due to **Pleural effusion**

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

Major findings: **None**  
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) **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?

While at work? (Specify type of place) (e) Means of injury

23. Signature **[Signature]** (M. D. or other) **MD**  
Address **Mexico, Mo** Date signed **3/25/44**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 4-44-818

Date Filed APR 11 1944

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

*W. W. Arnold*

Licensed Embalmer No.

*3569*

P. O. Address

*Mexico W.*

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.