

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 8 1944
Registration District No. 134

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17324
State File No. 17324

Primary Registration District No. 3003 Registrar's No. 38

1. PLACE OF DEATH:
(a) County Barry
(b) City or town Monett
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Davis' Nursing Home - 300 Frisco Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days + 13 hrs.
(Specify whether years, months or days)
In this community over 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Barry
(c) City or town Monett
(If outside city or town limits, write "RURAL")
(d) Street No. 405 3rd Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3. (a) PRINT FULL NAME Nancy Jane Hopkins
(b) If veteran, name war None
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 17th
year 1944 hour 2 minute A.M.

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ed John Hopkins
6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased February 24 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 7 - 1944, to May 17 - 1944, that I last saw her alive on May 16 - 1944 and that death occurred on the date and hour stated above.
Immediate cause of death Uremic Poison Duration

8. AGE: Years Months Days If less than one day
74 2 23 hr. min.

Due to Cancer of Bladder 14 years
Due to

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

Other conditions Prostatic Neck of Uterus 3-12-44
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER
12. Name Stephen Cowan
13. Birthplace Not Known
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Jane Wilmoth
15. Birthplace Not Known
(City, town, or county) (State or foreign country)

Major findings: Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Dr P.C. Hopkins

(b) Address 333 E. McDaniel - Springfield Mo.

17. (a) Burial (b) Date thereof May 18 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 900 F Cemetery - Monett Mo

18. (a) Signature of funeral director Callaway's

(b) Address 102 Dunci St. Monett, Mo

19. (a) May 18 1944 (b) Audna Willoughby
(Date received local registrar) (Registrar's signature)

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?

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

23. Signature R. Ferguson (M.D. or other)
Address Monett, Mo Date signed 5-18-44

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

RECEIVED

District Health Officer No. 6,

District File Number 644-679

Date Filed JUN 6 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.....

J. D. Buchanan

Licensed Embalmer No. 3179

P. O. Address Monett 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *June 38*
Registrar's No. *38*

Registration District No. *13* Primary Registration District No. *3003*

1. PLACE OF DEATH:
(a) County *Barry*
(b) City or town *Monett*
(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 *Nancy Jane Haphen*
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 *m*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years _____ days
7. Birth date of deceased *Feb. 2* (Month) (Day) (Year)

8. AGE: Years *78* Months *2* Days *2* (If less than one day, _____ min.)

9. Birthplace *Ark.* (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 _____ day _____ year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death *Uremic Poison* Duration _____

Due to *Cancer of Bladder 1 yr.*

Due to *caused from fall - home*
Other conditions *Fracture neck of femur - 3-12-48*
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy *186a*
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 *4-3-48*
(c) Where did injury occur *Home - Monett Barry Mo.* (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) (c) Means of injury _____

23. Signature *L. Ferguson* (M. D. or other) *M.D.*
Address *Monett Mo.* Date signed *6-30-48*

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

SUPPLEMENTARY

17324

1944 JUL 12 PM 1 5

POST OFFICE
DIVISION

U.S. DEPARTMENT OF COMMERCE