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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 13 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28352

Registration District No. 234 Primary Registration District No. 5816 Registrar's No. 17

1. PLACE OF DEATH:

(a) County MORGAN

(b) City or town RURAL RICHLAND TWP (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MORGAN 71

(c) City or town RURAL (If outside city or town limits, write "RURAL") 0

(d) Street No. 1/2 MI. WEST OF FLORENCE (If rural, give location) 0

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME MARY JANE HOPKINS

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

4. Sex FEMALE 5. Color or race 1 WHITE 6. (a) Single, widowed, married, divorced 2 WIDOWED

6. (b) Name of husband or wife WM. M. BROWN 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased SEPT. (Month) 6 (Day) 1867 (Year)

8. AGE: Years 76 Months 11 Days 22 If less than one day ..... hr. ..... min.

9. Birthplace BENTON CO. (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business .....

FATHER
12. Name WM. HOPKINS
13. Birthplace UNKNOWN (City, town, or county) MO. 0 (State or foreign country)

MOTHER
14. Maiden name ELIZABETH SMITH
15. Birthplace UNKNOWN (City, town, or county) MO. 0 (State or foreign country)

16. (a) Informant CLARENCE BROWN

(b) Address FLORENCE MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 30 1944 (Month) (Day) (Year)

(c) Place: burial or cremation CHANEY CHAPEL CEM

18. (a) Signature of funeral director Rapp & Stevenson

(b) Address Stover Mo

19. (a) Aug 31-44 (Date received local registrar) (b) Henry Kipp (Registrar's signature)

1080

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 28th year 1944 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from Aug 10 1944 to Aug 28 1944 that I last saw her alive on Aug 28 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis — Duration 4 yrs

Due to Arterio Schoases

Due to 938

Other conditions (Include pregnancy within 3 months of death) Robt Fogle

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 Robt Fogle (M. D. or other) MD

Address Otterville Mo Date signed 8/31/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 844-1059
Date Filed 9-12-44

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 J. L. Stevinson

Licensed Embalmer No. 4073

P. O. Address Stover 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.