

S. No. 2
OM-5-43
v. 5-17-39
I X36671

34397

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 20 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 121

Registration District No. 150

Primary Registration District No. 5572

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Prairie sup
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
RR # 2 5 mi N.W. of Lees Summit
(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) 50 yrs

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Rural RR # 2
(If outside city or town limits, write "RURAL")

(d) Street No. 5 mi N.W. of Lees Summit
(If rural, give location)

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

3. (a) PRINT FULL NAME Francis Marion Hopper

3. (b) If veteran, name war No

3. (c) Social Security No. 210

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Feb 21 1855
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>89</u>	<u>6</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Wm Hopper

13. Birthplace Ind 1
(City, town, or county) (State or foreign country)

14. Maiden name Mary Rayburn

15. Birthplace Ind 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jennie Williamson

(b) Address Lees Summit Mo RR 2

17. (a) Burial (b) Date thereof 7-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Co. Mo

18. (a) Signature of funeral director H. B. Lange fore

(b) Address Lees Summit Mo

19. (a) Sept 7, 1944 (b) F. M. Schuler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5
year 1944 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from 8-4-44 to 9-5-44
that I last saw him alive on 9-5-44
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Senility

Duration ?

Due to _____

Due to _____

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

Major findings: 93d

Of operations _____

Of autopsy _____

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? _____ (c) Means of injury _____

23. Signature [Signature] (M. D. or other) MD
Address Lees Summit Mo Date signed 7-6-44

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

00800

1862

(Licensed Embalmer's Statement on Reverse Side)

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.B. Langford

Licensed Embalmer No..... *3833*

P. O. Address..... *Leis Summit M*

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.