

FILED MAR 10 1945

State File No. \_\_\_\_\_

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Washington mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 325 E. 5th St. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 years years, months or days

3. (a) PRINT FULL NAME EMANUEL ALVIN HOPFER

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Katharine Hopper 6. (c) Age of husband or wife if alive 75 years  
7. Birth date of deceased Sept. 30 - 1861  
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired machanic

11. Industry or business Iron Works

12. Name Emmanuel Hopper

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

14. Maiden name Catherine LeBlanc

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

16. (a) Informant Mrs. A. G. Hopper

(b) Address Washington Mo

17. (a) Burial (b) Date thereof 2-8-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Mo

18. (a) Signature of funeral director W. H. ...

(b) Address Washington Mo  
(c) Date received local registrar 2-6-1945 (Registrar's signature) Frank R. Beebe

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin  
(c) City or town Washington mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 325 E. 5th St. 1  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5 year 1945 hour 2 PM minute 57 M.  
21. I hereby certify that I attended the deceased from Oct 4 - 1944 to Feb 5 - 1945  
that I last saw him alive on Feb 5 - 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Prostatitis Duration 2 Wks  
Due to Subacute nephrosic Influenza infection 2 Wks  
Other conditions 1 inf  
(Include emergency within 3 months of death)

Major findings: Of operations None Of autopsy no 137th  
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?  
While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. J. Goodrich (M. D. or other) \_\_\_\_\_  
Address Washington Mo Date signed 2-6-45

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

6  
6  
2

1181

RECEIVED  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed 9-9-45

**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. ~~2229~~  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 2464

P. O. Address Washington 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.**