

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24708

FILED JUL 16 1945

3-95-8

Registration District No. 952

Primary Registration District No.

Registrar's No. 32

1. PLACE OF DEATH:

(a) County PIKE

(b) City or town New Hartford 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 MO (b) County Pike 82

(c) City or town New Hartford - 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 _____

3. (a) PRINT FULL NAME RALEIGH LEE HOPKINS

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 12 P.
year 1945 hour 9 minute _____ M.

21. I hereby certify that I attended the deceased from May 20, 1945, to June 12, 1945,
that I last saw him alive on _____, 19____,
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dec 10 1892
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Prostate Duration 1 yr

Due to Metastasis from Prostate

Due to _____

Other conditions (Include pregnancy within 3 months of death) 5/11

8. AGE: Years 52 Months 5 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation Straw Box

Major findings: Carcinoma of Prostate

Of operation Colony of white soft

Of autopsy Prostate

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name Sterling June Hopkins

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

14. Maiden name Mary Exman

15. Birthplace New Hartford Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Laurence Shepherd

(b) Address New Hartford, Mo.

17. (a) Burial (b) Date thereof June 14, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashley Mo.

18. (a) Signature of funeral director Walter B. Ashford

(b) Address Bowling Green Mo.

19. (a) June 25-48 (b) of Bowling Green
(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) (c) Means of injury no.

23. Signature J. M. M. Ashford (M.D. or other) no.

Address Bowling Green Date signed 6/1/45

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

1148

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 7-45-1063
Date Filed JUL 13-1945

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

Objected to Embalming

....., Registered Apprentice No.

working under my personal supervision.

Signed *Grace Barfield*

Licensed Embalmer No. *2204*

P. O. Address *Bowling Green, Va.*

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. aug
Registrar's No. 32

Registration District No. 277 Primary Registration District No. 5950

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Normal Hartford Mo
(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 _____ (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 _____

3. (a) PRINT FULL NAME Raleigh J. Hopkins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dec 16
(Month) (Day) (Year)

8. AGE: Years 52 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 25/48 (b) Sam Frank Hardin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

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 _____

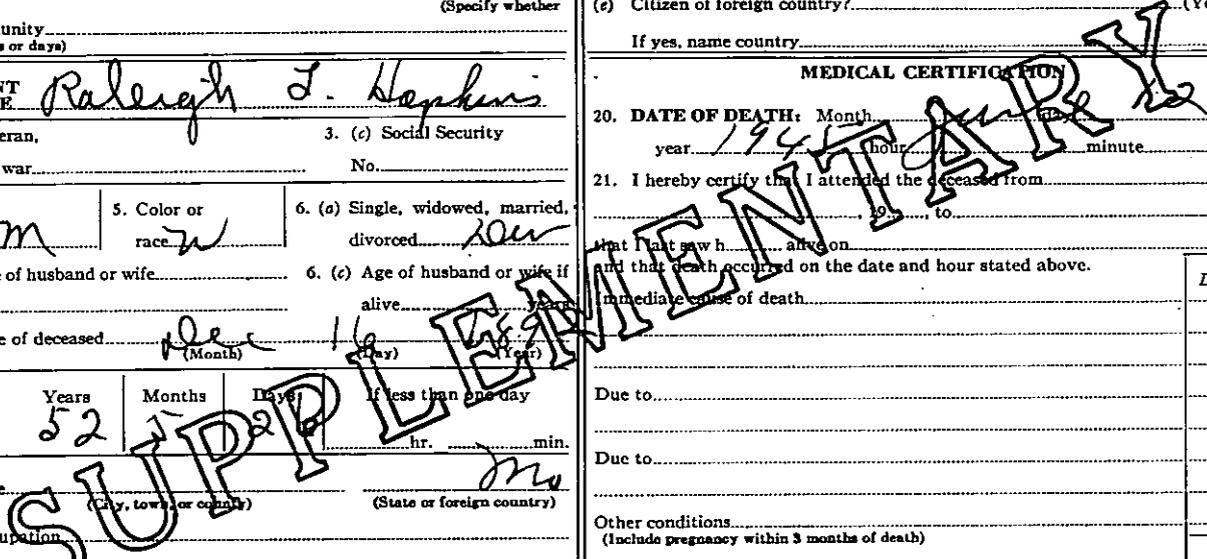
(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____



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

5-24708