

FILED NOV 10 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9339

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2318 So. 10th Street /
(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)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL") 2317

(d) Street No. 2318 So. 10th
(If rural, give location) 9

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME ROSE HOPPER

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female /

5. Color or race White

6. (a) Single, widowed, married, divorced. 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct. 28 1945
(Month) (Day) (Year)

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

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Columbus Hopper

13. Birthplace Gusty Ark. /
(City, town, or county) (State or foreign country)

14. Maiden name Fanny May Bishop

15. Birthplace Unknown Miss. /
(City, town, or county) (State or foreign country)

16. (a) Informant Columbus Hopper

(b) Address 2318 So. 10 Street

17. (a) Burial (b) Date thereof Oct. 29, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director A.W.M. Laughlin

(b) Address 2301 Lafayette

19. (a) OCT 29 1945 (b) J.F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th
year 1945 hour 2 minute 0 a: M.

21. I hereby certify that I attended the deceased from Oct 28, 1945, to _____, 19____
that I last saw her alive on October 28, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity
6 and one half months gestation

Due to _____

Due to _____

Other conditions 151
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

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)

(a) Means of injury 0

23. Signature Leroy E. Ellison (M. D. or other) NID

Address 3610 So Broadway Date signed 10-29-45

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

20
17
9

STATEMENT BY LICENSED EMBALMER

Not embalmed

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.....

C. W. Cooper

Licensed Embalmer No. *3830*

P. O. Address. *2301 Lafayette*

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.