V. S. No. 2
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Rev. 5-17-39
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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. 31996

FILED NOV 2 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9272

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

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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: Homer G Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17/8
(If outside city or town limits, write "RURAL")

(d) Street No. 31 S Leonard 9
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary Hopson

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 3

5. Color or race Col

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Bud Hopson

(c) Age of husband or wife if alive 60 years

7. Birth date of deceased Jan 19, 1901
(Month) (Day) (Year)

8. AGE: Years 44 | Months ~~Jan.~~ 19 | Days ~~19~~ 3 | If less than one day hr. min.

9. Birthplace Miss. Vicksburg 1
(City, town, or county) (State or foreign country)

10. Usual occupation Maid

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Zilpha Jones
15. Birthplace Miss. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret Johnson
(b) Address 3113 Laclede

17. (a) Burial (b) Date thereof 10-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director [signature]
(b) Address 3517 Laclede Ave

19. (a) OCT 26 1945 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22
year 1945 hour 6 minute 30 P M.

21. I hereby certify that I attended the deceased from Oct. 17, 1945, to Oct. 22, 1945
that I last saw her alive on Oct. 22, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Glomerulonephritis	Unk
Hypertension; Uremia	
Due to	
Due to	
Other conditions Mild Congestive Failure (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy NO

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 B. H. Phillips (M. D. or other)
Address 1601 N Whittier Date signed 10/24/45

(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 Melvin Edward Green, Registered Apprentice No. 383, working under my personal supervision.

Signed P. M. Green

Licensed Embalmer No. 1173

P. O. Address 5517 Soelede Ave

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.