

U. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH
1003

State File No. **39291**
Registrar's No. **11450**

FILED JAN 31 1946
Registration District No. _____

Primary Registration District No. _____

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

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:
City Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hr.
3 yr. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph H. Hopper
3. (b) If veteran, name war 1
3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Tillie Hopper
6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased: July 10 1891
(Month) (Day) (Year)

8. AGE: Years 54 Months 5 Days 16
If less than one day _____ hr. _____ min.

9. Birthplace: Boon Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Electric suply Man

11. Industry or business _____
12. Name Owen Hopper
13. Birthplace Boon Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Vaughn
15. Birthplace Manatau Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Tillie Hopper
(b) Address 5018 Claxton Ave.
17. (a) Burial (b) Date thereof Dec. 29 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Siedrich Funeral Home
(b) Address 8319 Halls Ferry Rd.
19. (a) DEC 27 1945 (b) J. P. Bruner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5018 Claxton Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 26
year 1945 hour 3 minute P.M. M.
21. I hereby certify that I attended the deceased from Dec 20
1945 to Dec 25, 1945
that I last saw him alive on Dec 25, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia 9 days
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 108
Major findings: _____
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature R. R. Meivorn (M. D. or other) MD
Address 5330 General Ave Date signed 12/27/45

(Licensed Embalmer's Statement on Reverse Side)

5330 General Ave

MOTHER FATHER

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

John Gyonosh

Licensed Embalmer No. *3398*

P. O. Address.....

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.