

FILED MAR 18 1946

Registration District No. _____

Primary Registration District No. **3000**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Nursing Home #1 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Live** _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**
(c) City or town **Novinger**
(If outside city or town limits, write "RURAL")
(d) Street No. **R. R. #1**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Callie Jerome Hopper**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **490-18-4150**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased **July 24 1880**
(Month) (Day) (Year)

8. AGE: Years **65** Months **6** Days **25** If less than one day _____ hr. _____ min.

9. Birthplace **Adair Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Miner**

11. Industry or business **No. 11 Mine**

MOTHER FATHER { 12. Name **Samuel Hopper**
13. Birthplace **Unknown Kv.**
(City, town, or county) (State or foreign country)
14. Maiden name **Frances Dockery**
15. Birthplace **Unknown S. Carolina**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rev Farr**
(b) Address **Yarrow, Missouri**
17. (a) **Burial** (b) Date thereof **2/22/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Lutz Cemetery**

18. (a) Signature of funeral director **J. W. Wiley**
(b) Address **Kirksville, Missouri**
19. (a) **3-3-46** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month **Feb.** day **19** year **1946** hour **9:00** minute _____ P: _____ M.

21. I hereby certify that I attended the deceased from **Feb. 15**, 19**46** to **Feb 19**, 19**46**.
that I last saw him alive on **Feb 19**, 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Failure** Duration **hrs**

Due to **Hypertension Heart Disease** yrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy **102**
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) _____ (Specify type of place) (e) Means of injury _____
23. Signature **Geo. Hanson** (M. D. or other) **MD**
Address **Kirksville, MO** Date signed **4-27-46**

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

RECEIVED
District Health Officer No. 10
District File Number 3-46-508
Date Filed MAR 15 1946

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 D. E. Riley
Licensed Embalmer No. 4181
P. O. Address Rockville MD

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.