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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18507**
Registrar's No. **90**

Registration District No. **310** Primary Registration District No. **6051**

1. PLACE OF DEATH:
(a) County **St. Charles**
(b) City or town **"Rural"**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2 miles West of St. Charles on Hwy 40
(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 **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5934 Plymouth**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Anna Mae Hopkins**
3. (b) If veteran, name war **NIL**
3. (c) Social Security No. **NIL**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **25**
year **1947** hour _____ minute **P.** M.
21. I hereby certify that I attended the deceased from
May 26 19 **47** to _____ 19 _____
that I last saw h. _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

4. Sex **Female** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Gray B. Hopkins**
6. (c) Age of husband or wife if alive **61** years
7. Birth date of deceased **May 30 1894**
(Month) (Day) (Year)

Immediate cause of death _____
automobile accident
Due to **fractured skull and chest injuries**
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE:
Years **52** Months **11** Days **25**
If less than one day _____ hr. _____ min.

9. Birthplace **Georgia**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**
11. Industry or business _____
12. Name **James D. Sterling**
13. Birthplace **Alabama**
(City, town, or county) (State or foreign country)
14. Maiden name **Savana Dennard**
15. Birthplace **Georgia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Gray B. Hopkins**
(b) Address **5934 Plymouth-St. Louis, Mo.**
17. (a) removal **(b) Date thereof** **May 27-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Eulaski, Georgia**
18. (a) Signature of funeral director **H. C. Dallmeyer & Sons Co.**
(b) Address **800 N. 2nd-St. Charles, Mo.**
19. (a) 5-29-47 **(b) Mrs. W.J. Hamilton**
(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) **accident**
(b) Date of occurrence **May 25, 1947**
(c) Where did injury occur? **Hwy. 40 St. Chas. Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place Highway 40.
While at work? **no** (Specify type of place) **Bus & Ford**
(e) Means of injury
23. Signature **Miriam Marching Cooney**
Address **Monticello, Mo.** **Date signed** **5-26-47**

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

MOTHER FATHER

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

Date Filed JUN 4 1947

District File Number

District Health Officer No. 9

RECEIVED

JUN 12 1947

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 Joseph I Landolt
Licensed Embalmer No. 4189
P. O. Address St. Charles

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JuneJuneRegistration District No. 310Primary Registration District No. 6051Registrar's No. 90

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(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)3. (a) PRINT
FULL NAMEAnna M Hopkins3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex F 5. Color or race W 6. (a) Single, widowed, married,
divorced m6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____7. Birth date of deceased May 22 1945
(Month) (Day) (Year)8. AGE: Years 52 Months 11 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) May 29 1947 (b) Maime H. Smith
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 5-
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her 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 sta-
tistically.

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

SUPPLEMENTARY

6/12/47

18507