

FILED OCT 23 1948

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8955**

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Luke's Hospital  
(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 NAME

Albert Hopper Jr

3. (b) If veteran, name war

No

3. (c) Social Security No.

361-14-5674

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 March 9 1925  
(Month) (Day) (Year)

8. AGE: Years 23 Months 7 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Gays Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Bookkeeper

11. Industry or business \_\_\_\_\_

12. Name Albert Hopper Sr.

13. Birthplace Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Nellie Smith

15. Birthplace Gays Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Nellie Hopper

(b) Address Gays Ill.

17. (a) Removal (b) Date thereof 10-15-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gays, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) OCT 15 1948 (b) J. B. Basette  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Moultrie  
(c) City or town Gays  
(If outside city or town limits, write "RURAL")  
(d) Street No. N.R. (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14  
year 1948 hour 8.00 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 12 Oct 48  
to 13 Oct 48  
that I last saw him alive on 13 Oct 48  
and that death occurred on the date and hour stated above.

Immediate cause of death Brain Abscess  
Type undetermined  
Due to Congenital Cystic  
Due to Disease of A Lower Lung  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration 3 mo.  
20  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Major findings: Same as above  
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)  
(a) Means of injury \_\_\_\_\_  
23. Signature Robert J. Wootley  
Address 4500 Olive Date signed 10/15/48

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

MOTHER FATHER

mil

**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 Gustav W. Dieterle  
Gustav W. Dieterle

Licensed Embalmer No. 4329

P. O. Address St. Louis, Mo.

**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.**