

FILED SEP 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 929123BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 132

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|--|--|-----------------------------------|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Scott</u> <u>Mo. Delta Comm. Hosp.</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u> | | c. LENGTH OF STAY (in this place) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u> <u>1002</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hosp.</u> | | | d. STREET ADDRESS (If rural, give location) <u>510 North Main</u> <u>0</u> | | |

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|--|------------------------|-------------------------|------------------|----------|-------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | |
| a. (First) <u>Willie</u> | b. (Middle) <u>Mac</u> | c. (Last) <u>Hopper</u> | (Month) | (Day) | (Year) |
| | | | <u>Aug.</u> | <u>8</u> | <u>1950</u> |

| | | | | | | | | |
|--|----------------------------------|--|-------------------------------------|--|---------------------------|---|--------------------------|-------------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>11/28/27</u> | 9. AGE (In years last birthday) <u>37</u> | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRS. Hours | IF UNDER 1 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | |

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|---|--|--|--|---|--|
| 13a. FATHER'S NAME <u>Newton Harwell</u> | | 13b. MOTHER'S MAIDEN NAME <u>Catherine Vaughn</u> | | 14. NAME OF HUSBAND OR WIFE <u>Paul Hopper</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME <u>Paul Hopper - Sikeston Mo</u> | |
| | | | | ADDRESS | |

| | | | | | |
|---|--|-----------------------|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Toxemia of pregnancy</u> | | ANTECEDENT CAUSES | | | |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (b) | | | |
| | | DUE TO (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | <u>655*</u> |

| | | | | | | |
|------------------------|--|----------------------------------|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|------------------------|--|----------------------------------|--|--|---|--|

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|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 8-8, 1950, to 8-8, 1950, that I last saw the deceased alive on 8-8, 1950, and that death occurred at 10:20 P.M., from the causes and on the date stated above.

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|--|--|-------------------------------------|--|-----------------------------------|--|
| 23a. SIGNATURE <u>Edw. Sargent M.D.</u> (Degree or title) | | 23b. ADDRESS <u>Sikeston, Mo</u> | | 23c. DATE SIGNED <u>8-8-50</u> | |
|--|--|-------------------------------------|--|-----------------------------------|--|

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|--|--|-----------------------------|--|--|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>8-11-50</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | | 24d. LOCATION (City, town, or county) (State) <u>Sikeston, New Madrid, Missouri</u> | |
|--|--|-----------------------------|--|--|--|--|--|

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|---|--|--|--|--|--|---------|--|
| DATE REC'D BY LOCAL REG. <u>Sept 19-50</u> | | REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Taylor Funeral Home, Sikeston, Mo</u> | | ADDRESS | |
|---|--|--|--|--|--|---------|--|

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED SEP 11 1958

SCOTT COUNTY HEALTH DEPARTMENT

CO. FILE NO. 958-

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *J. E. M. Mittle*
Licensed Embalmer No. 4695

P. O. Address *Saturday*

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.