

FILED AUG 4 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23079

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3027

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN KANSAS CITY	c. LENGTH OF STAY (in this place) 6 7 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2922 Olive St.		d. STREET ADDRESS (If rural, give location) 2922 Olive Street	

3. NAME OF DECEASED (Type or Print) a. (First) Theodore b. (Middle) Delancy c. (Last) Hopper	4. DATE OF DEATH (Month) (Day) (Year) 7-14-51
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH March 13, 1870	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 Wks. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY theatre stage hand	11. BIRTHPLACE (State or foreign country) Waterloo, N.Y.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Charles H. Hopper	13b. MOTHER'S MAIDEN NAME Betty Jane Smith	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 492-14-9455	17. INFORMANT'S SIGNATURE OR NAME Bertha M. Hopper ADDRESS Kansas City 2922 Olive
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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) Bronchopneumonia		3 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		49 1/2
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of prostate gland		3 years

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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov. 1949** to **July 14, 1951**, that I last saw the deceased alive on **July 14, 1951**, and that death occurred at **6:45 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE T. Reid Jones	T. Reid Jones M.D. (Degree or title)	23b. ADDRESS 1107 Bryant bldg	23c. DATE SIGNED 7-17-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 17 1951	24c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEMETERY	24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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DATE REC'D BY LOCAL REG. 7-17-51	REGISTRAR'S SIGNATURE Geraldine Holman	25. FUNERAL DIRECTOR'S SIGNATURE W. H. Newcomer's Sons ADDRESS 1331 - BRUSH CREEK KANSAS CITY, MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 Basil Woney

Licensed Embalmer No. 4724

P. O. Address Fashland, 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.