

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **12916**

No. 300
10.48 **FILED APR 14 1953**

BIRTH NO. _____ REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **3072** Registrar's No. **82**

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Saline	
b. CITY OR TOWN Marshall		c. CITY OR TOWN Marshall 0972	
c. LENGTH OF STAY (in this place) 1 1/2 yrs		d. STREET ADDRESS (If rural, give location) 585 N. Arrow	
d. FULL NAME OF HOSPITAL OR INSTITUTION 585 N. Arrow			

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) E c. (Last) HOPKINS			4. DATE OF DEATH (Month) (Day) (Year) April 8, 1953		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Nov. 25, 1860		9. AGE (in years last birthday) 92		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 6 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Leonard Stump		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE _____	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Geo. W. Landreth Marshall Mo	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH
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.					

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 4200	
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? _____	

22. I hereby certify that I attended the deceased from **1-2, 1952**, to **4-8, 1953**, that I last saw the deceased alive on **4-8, 1953**, and that death occurred at **4:30 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE John C. Reel MD (Degree or title)		23b. ADDRESS Marshall Mo		23c. DATE SIGNED 4-10-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-10-1953		24c. NAME OF CEMETERY OR CREMATORY Pleasant Ridge Cem.	
				24d. LOCATION (City, town, or county) (State) Dallas County Mo	

DATE REC'D BY LOCAL REG. 4-10-1953		REGISTRAR'S SIGNATURE R. Sidney J. Gray 385		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harry Hershberger Marshall, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 Joseph R. Mackler.....

Licensed Embalmer No. 4571.....

P. O. Address Marshall, 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.