

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

30595

FILED AUG 25 1953

State File No. 3201
Registrar's No. 2701

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| BIRTH NO. _____ | | REG. DIST. NO. <u>317</u> | | PRIMARY REG. DIST. NO. <u>541</u> | | State File No. <u>3201</u> | | Registrar's No. <u>2701</u> | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>St Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u> | | c. LENGTH OF STAY (in this place) <u>1 day</u> | | c. CITY OR TOWN <u>Robertson</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Louis County Hosp</u> | | | | e. STREET ADDRESS: (If rural, give location) <u>Edwards Ave 4079</u> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>BLANCHE</u> | | | b. (Middle) _____ | | | c. (Last) <u>HOPKINS</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>8 9 53</u> | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u> | | 8. DATE OF BIRTH <u>16 May 1885</u> | | 9. AGE (In years last birth day) <u>68</u> | | if UNDER 1 YEAR Months _____ Days _____ | | if UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (City and State or foreign Country) <u>Madison Ind</u> | | | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | |
| 13a. FATHER'S NAME <u>Geo Lynch</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>John Hopkins</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. <u>None</u> | | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Chas Hopkins Robertson Mo</u> | | | | | | | |
| 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>Carcinomatosis - generalized</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. | | | | | | | | | |
| 19a. DATE OF OPERATION _____ | | | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 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) _____ | | | 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 <u>8-8</u> , 19 <u>53</u> , to <u>8-9</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>8-9</u> , 19 <u>53</u> , and that death occurred at <u>12:30P</u> m., from the causes and on the date stated above. | | | | | | | | | | | | | |
| 23a. SIGNATURE <u>Bilmut L. Thiel</u> (Degree or title) <u>M.D.</u> | | | | | | 23b. ADDRESS <u>601 S. BRENTWOOD</u> | | | 23c. DATE SIGNED <u>8/10/53</u> | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 24b. DATE <u>12 Aug 53</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u> | | | 24d. LOCATION (City, town, or county) (State) <u>Berkeley Mo</u> | | | | | | |
| DATE REC'D BY LOCAL REG. <u>8-10-53</u> | | REGISTRAR'S SIGNATURE <u>Herbert R. Dink</u> | | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bond Bros Humboldt Mo</u> | | | | | | | |

p.t. (Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

301

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
Signature of Student Embalmer

Signed *Edward A. Flynn*

Licensed Embalmer No. *24*

P., O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.