

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35493

State File No.

FILED OCT 26 1954

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9129

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY			
b. CITY OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>ST. LOUIS MO</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>ST. LOUIS CITY HOSPITAL</u>		• STREET ADDRESS (If rural, give location) <u>19 4117 Delmar Blvd</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u>		b. (Middle)		c. (Last) <u>HOPSON</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 7 1954</u>		5. SEX <u>Female</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Sept ? abt. 52</u>	
9. AGE (In years, if UNDER 1 year Months Days; if UNDER 1 year Hours Min.) <u>abt. 52</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) <u>Lincoln Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Not known</u>		13b. MOTHER'S MAIDEN NAME <u>Not known</u>		14. NAME OF HUSBAND OR WIFE	
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>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mary Ballard</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CARCINOMA OF OVARY</u> ANTECEDENT CAUSES Morbidity 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>HYPERTENSIVE CARDIOVASCULAR DISEASE - 20 YRS</u> <u>CEREBRAL VASCULAR ACCIDENT</u> <u>UTERINE MYOMA</u>			
19a. DATE OF OPERATION <u>30 SEPT. 54</u>		19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA OF OVARY WITH METASTASIS</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? <u>175X</u>	
22. I hereby certify that I attended the deceased from <u>9-16-54</u> , 19 <u>54</u> , to <u>10-7-54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>10-7-54</u> , 19 <u>54</u> , and that death occurred at <u>12:20 AM.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>Richard Thomas Wells M.D.</u>		23b. ADDRESS <u>1515 LAFAYETTE</u>		23c. DATE SIGNED <u>10-7-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-9-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cem</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis MO</u>		DATE REC'D BY LOCAL REG. <u>OCT 8 1954</u>			
REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Beal</u>			
ADDRESS <u>4303 Delmar</u>		(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.....
Signature of Student Embalmer

Signed.....
Daniel W. Dwyer

Licensed Embalmer No. *4802*

P. O. Address *3123 Kolla*

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.