

XC-370 098

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14436

SL #12536

STATE FILE NUMBER

FILED MAR 18 1957

318

1003

1975

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GAS CONADE				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN OTTERVILLE 0370		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
35 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL			Length of stay in 1b 46 days	37 d STREET ADDRESS BOX 34		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES W. HOPKINS				4. DATE OF DEATH Month Day Year FEBRUARY 26, 1957				
5. SEX MALE <input checked="" type="checkbox"/>	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/2/91	9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) OTTERVILLE, MO. 0		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME A. M. HOPKINS				14. MOTHER'S MAIDEN NAME GEORGIA A. BUTLER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE BRONCHOPNEUMONIA, POST OPERATIVE							INTERVAL BETWEEN ONSET AND DEATH UNK.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) - - - - - DUE TO (c) - - - - - 578								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GASTROINTESTINAL HEMORRHAGE							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) VA		20f. CITY, TOWN, OR LOCATION VAH, ST. LOUIS, MO.		COUNTY STATE		
21. Attended the deceased from 1/11/57 to 2/26/57 and last saw XXXX him alive on 2/26/57 Death occurred at 5:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) M.D. F. Westphalinger, M.D.				22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 2/26/57		
23a. BURIAL OR CREMATION REMOVAL (If removal) Removal 2/26/57		23b. NAME OF CEMETERY OR CREMATORY F. Westphalinger, M.D. Sedalia Mo		23d. LOCATION (City, town, or county) Sedalia Mo		(State)		
24. FUNERAL DIRECTOR Edward Fendler Mortuary 5611 South Grand			25. DATE RECD. BY LOCAL REG. FEB 27 '57		26. REGISTRAR'S SIGNATURE Carl Smith M.D.			

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Harry J. Schumacher*
Licensed Embalmer No. *767*

P. O. Address *5611 P.*

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.