

Health,
Welfare
Public
Service

300
-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30813
STATE FILE NUMBER

FILED OCT 14 1957

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 375

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		c. CITY OR TOWN <u>Deola</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIVERSITY INSTITUTION <u>Medical Center of Mo</u>		d. STREET ADDRESS (If outside, give location) <u>320</u>	
Length of stay in lb <u>3 Days</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>J</u> Last <u>Hopper</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>57</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 19, 1918</u>	9. AGE (In years last birthday) <u>40</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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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	11. BIRTHPLACE (City and state or country) <u>LOUISIANA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Roy Morris</u>	13b. MOTHER'S MAIDEN NAME <u>ETHEL LYTON</u>	14. NAME OF HUSBAND OR WIFE <u>Fred Hopper</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>L</u>	17. INFORMANT Address <u>Hospital Record Columbia Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Unknown type renal d - probable</u>		
DUE TO (c) <u>Chronic pyelonephritis or glomerulonephritis unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Staphylococci septicaemia</u>		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"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from Death occurred at <u>(10/9) 2:15</u> ^{10/5} a. m. on the date stated above; and to the best of my knowledge, from the causes stated. to <u>10/9</u> and last saw her alive on <u>10/9</u>

22a. SIGNATURE <u>Frank R. Mohr, M.D.</u> (Print name or title)	22b. ADDRESS <u>U of Mo Med Center, Columbia, Mo</u>	22c. DATE SIGNED <u>10/9/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-9-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOWRY CITY</u>	23d. LOCATION (City, town, or county) <u>LOWRY CITY MO</u>	(State)
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24. FUNERAL DIRECTOR <u>Goodrich J. Home</u>	ADDRESS <u>DSC 6019 Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 9, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
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(Licensed Embalmer's Statement of Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL CAUSES THAT MUST BE CAUSALLY RELATED.

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 *J B Goodrich*

Licensed Embalmer No. *3038*

P. O. Address *Osceola*

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.