

Health, Welfare  
Public  
Service

DR. Clarke

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021563

STATE FILE NUMBER

FILED JUL 7 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 2767

300  
-57

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SPRINGFIELD</b> <b>0396</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>		Length of stay in 1b <b>71 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>807 W. WEBSTER</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle Last <b>HOPPE</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>28</b> Year <b>1958</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 25 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>71</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>SPRINGFIELD, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>OTTO G. MAYER</b>		13b. MOTHER'S MAIDEN NAME <b>MARIE FRANCES KENNEDY</b>	14. NAME OF HUSBAND OR WIFE <b>HERMAN HOPPE</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT Address <b>HERMAN HOPPE</b> <b>SPRINGFIELD, MO.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinomatosis</b>			<b>3 months</b>
DUE TO (c) <b>Adenocarcinoma of fundus of uterus</b>			<b>15 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>2-4-57</b> to <b>6-28-58</b> and last saw <input checked="" type="checkbox"/> alive on <b>6-28-58</b> Death occurred at <b>10:50 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Michael J. Clarke M.D.</i>		22b. ADDRESS <b>Springfield, Missouri</b>	22c. DATE SIGNED <b>6-30-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7/2/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>
24. FUNERAL DIRECTOR <b>H.H. LOHMEYER</b> ADDRESS <b>SPRINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>7-1-58</b>	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 6 1959

STATEMENT BY LICENSED EMBALMER

*not*

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~is~~ embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

*met*

Signed *A. J. McLean*

Licensed Embalmer No. *2727*  
P. O. Address *Springfield*

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.