

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042640

STATE FILE NUMBER

FIND DEC 10 1958

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3098

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		c. CITY OR TOWN Columbia	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		d. STREET ADDRESS (If outside, give location) 513 South 6th Street.	
3. NAME OF DECEASED (Type or print) First Robert Middle Fred Last Hopper Sr.		4. DATE OF DEATH Month November Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.	11. BIRTHPLACE (City and state or country) Boone Co., Mo.
13a. FATHER'S NAME Clifton T. Hopper		13b. MOTHER'S MAIDEN NAME Mary Ann Berry	14. NAME OF HUSBAND OR WIFE Mathilda Hopper
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Earl Hopper, 508 Edgewood-Columbia, 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) Hemorrhage from an intracranial vessel DUE TO (b) Hypertensive cardio-vascular disease DUE TO (c) 443X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 16 days over 5 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
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	
21. I attended the deceased from Nov 10, 1958 to Nov 24, 1958 and last saw him alive on Nov. 24, 1958 Death occurred at 10:30 pm m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James B. Jones M.D.		22b. ADDRESS 337 W. Lockwood Hwy. Webster Groves 19, Mo.	
22c. DATE SIGNED 11-25-58			
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-25-58	
23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Columbia, Mo.	
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. 11-27-58	
26. REGISTRAR'S SIGNATURE Walter R. Ormbe M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

8961 7 1 1934

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 Stanley H. Dixon Licensed Embalmer No. 4193 P. O. Address St. L.

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.