

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013353

FILED APR 20 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 1567 Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>Margaret Kathryn</b> INSTITUTION <b>Nursing Home</b>		Length of stay in <b>5</b> years	d. STREET ADDRESS <b>2641 Forest</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>JOSEPHINE HOPKINS</b>			4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1959</b>		
---	--	--	---	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1877</b>	9. AGE (In years) to <b>81</b> (rhd) day	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
-------------------------	----------------------------------	--	---	---	--------------------------------	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired business college operator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>operator</b>	11. BIRTHPLACE (City and state or country) <b>Louisville, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	--	---	---

13a. FATHER'S NAME <b>Henry Hopkins</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Harris</b>	14. NAME OF HUSBAND OR WIFE <b>None</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>549-01-9025</b>	17. INFORMANT <b>Mrs. Robert W. Combe</b>	Address <b>203 East 67th St.</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>Broncho pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chr Myocarditis</b>	
	DUE TO (c) <b>Tembly</b>	<b>4-2-2-</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>none</b>		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.) <b>no</b>
---	---

20c. TIME OF INJURY Hour a.m. p.m. <b>no</b>
--

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>no</b>	20f. CITY, TOWN, OR LOCATION <b>no</b>	COUNTY	STATE
---	---	---	--------	-------

21. I attended the deceased from **June 1955** to **March 24, 1959** as saw her alive on **March 24, 1959** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>M. B. Casebolt MD</b>	(Degree or title)	22b. ADDRESS <b>4000 Baltimore</b>	22c. DATE SIGNED <b>3/24/59</b>
--	-------------------	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 26, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>
--	------------------------------------	--	---

24. FUNERAL DIRECTOR <b>Freeman Mortuary</b>	ADDRESS <b>Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-26-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
---	------------------------------------	--	---

M. B. Casebolt USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JE 1-8884

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 *Walter H. Erwin* .....

Licensed Embalmer No. *4352* .....

P. O. Address *K. C. no* .....

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.