

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028107

FILED VS AUG 31 1959 30

Registration District No. 30 Primary Registration District No. 5102 Registrar's No. 30

STATE FILE NUMBER

DED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Benton</u>		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>FRISTOE</u>		Length of stay in 1b <u>years</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 1/2 miles N.E. Fristoe</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>FRISTOE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last <u>SYBIL LOWKEEL HOPPER</u>				Month Day Year <u>Aug 21 1959</u>			
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 18, 1922</u>	9. AGE (last birthday) <u>36</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
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 <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Shawnee, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Everett Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Rachel Hampton</u>		14. NAME OF HUSBAND OR WIFE <u>Harold Hopper</u>		
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>None</u>		17. INFORMANT <u>Harold Hopper Fristoe, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Uremia</u>						<u>3 days</u>	
DUE TO (b) <u>Metastatic Cancer thru out pelvic area</u>						<u>6 months</u>	
DUE TO (c) <u>Primary Cancer of the cervix uterus</u>						<u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m.		Month, Day, Year					
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>April, 10, 1957</u> to <u>Aug., 21, 1959</u> last saw her alive on <u>Aug., 20, 1959</u> Death occurred at <u>8:45 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) <u>Embalmer</u>				22b. ADDRESS <u>Warsaw, Mo.</u>		22c. DATE SIGNED <u>8-23-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 23, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fristoe Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Fristoe Benton Co, Mo</u>			
24. FUNERAL DIRECTOR <u>John J. Liser</u>		ADDRESS <u>Warsaw</u>		25. DATE RECD. BY LOCAL REG. <u>Aug. 23 - 1959</u>		26. REGISTRAR'S SIGNATURE <u>Wm. A. Logan</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed John F. Reser

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.